Leadership development for midlevel managers

A case study of a program at Akershus University Hospital

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Abstract

Title: Leadership development for midlevel managers: a case study of a program at Akershus University Hospital

Project description: The thesis is an evaluation of an internal leadership development program for midlevel managers at Akerhus University Hospital (Ahus). It is conducted as a case study based both on participant interviews and data provided by Ahus.

Background: Ahus has gone through significant changes and increased its catchment area with 160 000 new citizens in 2011. As a result of a nationwide commitment to improve leadership in specialist healthcare, and to reach the goals of the hospital's strategic plan, internal leadership programs for different leadership levels has been started up.

Aim: Explore participants' experiences with the mid-level leadership development program in order to assess how the hospital can adapt the program to fit the needs and expectations of the leaders in the best possible way.

Methods: A case study that draws on different leadership theories, existing empirical evidence, survey data and results from seven semi-structured interviews with individuals who participated in the program.

Conclusion: Participants were generally satisfied with the program, and with their performance in the leadership role. There were diverging opinions about the teaching methods, and the majority preferred the basis groups to the plenary lectures. Several participants struggled to render concrete outcomes from the program, indicating a need to make it more specific. Similar to what have been found in previous studies was it found indications of the unitary management reform still not being fully acknowledged. A need for further leader-support was uncovered, both in regards to administrative tasks and in providing support networks.

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Table of content

1 Introduction

In its basic form, leadership is not something new – neither is it a trait unique to humans, but also seen in different forms among other species. Wolf packs leaders organize group defense, and alpha-male chimpanzees deal with conflicts by eradicating aggressive behavior (Koykka & Wild, 2015). It is, however, only in recent times that we have tried to pin it down with explanations and definitions. Leadership has during the past century become an academic field of study as we have started building up and making ourselves dependent on sophisticated organizational structures. As Brunsson (1989) explained it: we are living in an increasingly complex society. To generate coordinated collective action needed to keep the society going, we have built organizations. The rationale is that these structures provide us with something that either not as efficient - or not at all – could have been produced without collective action. The growing demands have resulted in a transformation of the situation within organizations. Organizations, besides producing the products, now have to adapt to a demanding environment with numerous rules, norms and interests (Brunsson, 1989). To survive and to succeed in this new and continuously evolving environment the organizations need to maneuver wisely. Particularly recruiting and developing the next generation of leaders is of crucial importance. This raises questions numerous of researchers are trying to answer; how do we find these leaders, and what make them capable of success? In this thesis the focus will be directed on the hospital organization. A Swedish man supposedly once said that in a hundred years everything would be changed, except from the priest in the church and the teacher in the classroom, they would stay the same. The same could have been argued to be applicable for the hospital, which indeed is one of the oldest organizational structures we have. However, the hospital organization is not shielded from the changing and demanding environment, and thus has to be adaptable. Imposing changes to a organization with deep rooted traditions is no simple task. Nor is it to be one of those set to lead under these circumstances. This thesis will thus look into a field of much debate and controversy: the hospital organizations mid-level leaders.

1.1 Background for study

Akershus University Hospital (Ahus) is one of the most modern hospitals in Europe, and one of the biggest hospitals in Norway. In the recent years, it has gone through an extensive transformation considering both the catchment area and the internal organizational structure. Ahus (2011) have a high focus on leadership development in accordance with both national guidelines and their own strategic plan. A common understanding of leadership and the leader role is considered the basis for further organizational development. Based on this strategy the hospital has started an internal leadership development program offered to leaders on different organizational levels (Akershus universitetssykehus, 2011).

This thesis is a study of the development program offered to the hospitals mid-level leaders. The programs target group is mid-level leaders both with and without clinical background, throughout all departments of the hospital. Currently have two groups completed the program, and a third group has just started. The goal is to get all the mid-level leaders through, and about 50 percent of the leaders have participated so far. The project was planned in cooperation with the Ahus' Department of Human Resources.

1.2 Aim of study

The aim of this study is to explore participants' experiences with the internal leadership development program at Ahus, in order to assess how the hospital can adapt their program to fit the needs and expectations of the mid-level leaders in the best possible way.

1.3 Presentation of research questions

- What data and evaluation results exists about the program?
- How do program participants perceive their leadership role, and what support do they need?
- What do program participants' experience as outcomes of participating in the internal leadership development program?
- What are participants' reflections on the program content and structure?

1.4 Structure of the thesis and clarification of central concepts

This thesis consists of four main chapters. The first chapter, the introduction, consists of an overview of historical leadership theory followed by a look at Mintzbergs (1989) professional organization. A short introduction to the Norwegian healthcare system is given accompanied by an elaboration of the uniform leadership reform in Norwegian hospitals that have had great implications for the management structure. I will give an account of the US Army's conceptual leadership framework before I present a section containing empirical knowledge and models on leadership development. Lastly is a short presentation of the characteristic of what has become known as the Scandinavian management style is provided. The methodological chapter presents the work with this case study in steps from planning the study, to conducting the interviews, analyzing the interview and the document data and placing it in context and meaning. The result chapter is divided into two, part one presents the document analysis, and part two consists of interview data. Lastly, the findings are discussed, the implications for the hospital are identified, and the work is rounded off with a conclusion.

1.5 Clarifications of concepts

1.5.1 Leadership versus management

In the Norwegian language, leadership and management are referred to with the same word - "ledelse". Northouse (2012) treats leadership as the innovative and direction-setting position and management as a operationalizing of the set tasks. This is a reoccurring perception and can be pictured as the leader drawing a map and the manager putting the map to use by orienting the team from point A to point B. There are however inconsistencies in how the concepts are used. Some argue leadership is a part of the management process, others mean the opposite, while some oppose that they are a part of the same process at all (Jeon et al. 2010). Even the English research literature reveals great inconsistencies. For the purposes of this thesis it is chosen to consider the expressions as interchangeable when referring to the position and the role the research subjects possess. This decision is made due to the observations of different theories and literature using the terms differently but approaching

the same issues. It is thus believed that choosing only one of the concepts would result in potential important sources being left out.

1.5.2 Leading from the middle

Mid-level leaders are defined as managers working two levels below the CEO and one level over line workers and professionals (Huy, 2001). Many mid-level leaders find themselves in a hybrid position where they besides being a leader also work in direct patient care (Buchanan et al., 2013). The numerous reforms in healthcare affect the organization as a whole and put an especially high pressure on those who must lead this change. Mid-level leaders are rarely involved in introducing any organizational change. However, these are often the people given the most challenging job in implementing it (Fagerström & Salmela, 2010). The mid-level leaders are exposed to prejudice regarding their functionality and cooperation abilities in the organization. According to Huy (2001) they are often perceived as organizational old "dinosaurs" consequently resisting change. It has however been discovered that the mid-level leaders are more valuable for the organizations than they have been given credit for, and that they often are the source of important observations and innovation in the organizations (Huy, 2001).

1.5.3 Clinical leadership

Clinical leadership has been defined several different ways. In this project, it is chosen to operate with one of the wider definitions. Based on Edmonstone (2005) it includes leaders in the healthcare organization with a clinical background themselves, but regardless of their current position being full-time managerial or a position mixing the two areas. The emphasis on getting clinicians into leadership positions is increasing across the globe. Due to the way the hospital organization work, these professionals need to be involved in the process to successfully implement change (Mintzberg, 1989). They have the direct ability to affect cost containment and other implementations of reform changes (Degeling & Carr 2004; Degeling et. al, 2003). Mountford and Webb (2009) found that clinicians are important in leadership positions in the healthcare organization, because they have the technical knowledge to make strategic choices and because they are the ones exercising the implication in the front line. A UK study of the NHS similarly found that hospitals scoring high on clinicians in leadership position, did about 50 percent better on important performance drivers compared to the

hospitals with a lower participation of clinicians in leadership positions (Castro et al., 2008). Educating clinical leaders through attending courses is thus clearly a good investment in human capital. However, due to the complex healthcare organization, it is also important to take into consideration the social aspects and to increase the skills of co-operation and collaboration across the organizational layers and lines (Swanwick & McKimm, 2011).

1.6 Theoretical perspectives - Leadership emerges as a science and practice

Max Weber became the pioneer of Western management theory when he around the turn of the twentieth century defined the organizational bureaucracy. According to Burns et al. (2012), has Webers' bureaucracy vertical hierarchies and horizontal divisions separating different labor functions and defined governing actions. Controlled within a legal framework it was organized to work with the topmost efficiency. The prominence of bureaucracy within an organization was according to Burns associated with the organization's size and age and thus particularly evident in big and old organizations (Burns et al., 2012).

Following Weber, the orientation known as scientific management or "Taylorism", applied science into management with the aim of increasing control and productivity. A good illustration of this era is the workers on the assembly line. The hierarchical structure was evident; the leader was at the top and had high control over the workers on the floor. This way of thinking, typically known as "top-down", have had a great impact on management practices. However, not long after, Elton Mayo and his "human relations school" brought another new perspective into the management theory. It started out as a project based on scientific management but resulted in some unexpected findings that evoked the idea of workers being less predictable in terms of motivations and efficiency than Taylors' theories implied. Mayo found that the workers also were affected by human sentiments. This lead to an understanding that the workers best interest should be taken into consideration when improving organizational output. Thus, had a "bottom-up" way of thinking been born (Burns et al., 2012).

By the mid 20th century, the schools of Taylor and Mayo were seen as the two dominant, and opponent, within management theory. Following these developments came the decision-making school, the "neo-Weberian" model. It adapted neither Taylors' “top-down” way of thinking or Mayos' “bottom-up”. Instead, it introduced a new approach where the focus was directed towards the relations and the interactions between the leaders and the followers. The decision-making school focused on all the mid-level managers who had appeared along with the increasingly growing and professionalized organizations. Based on the idea of bounded rationality - that these leaders had limited abilities in making good decisions for the organization - an assumption evolved that they should be put under increased control. By acknowledging that conflicts could arise from the differentiating goals of the workers and of the organization, the decision-making school aimed at reaching agreements though bargaining and negotiation between the parts (Burns et al., 2012).

For a long time, the main discussion was about whether being a good leader was something connected to personality (the trait approach) or a skill that could be acquired (the skills approach). There are however several more approaches and theories, as seen in Northouse (2012). The style approach emphasizes the leaders behavior, what they do and how they act, which shifts the perspective away from just focusing on the leader and expands it to include the actions towards colleagues in different contexts. Another widely acknowledged approach is the situational approach. This approach focuses more on the situational environment around the leader and has as its premise that efficient and good leadership will require continuous adaption from the leader to adapt to the surroundings. While many leadership theories focus on either the leaders or the followers, the LMX-theory focuses, like the decision-making school, on the processes and the relationship between the leaders and the followers. In the beginning the LMX theorists had their main focus on the so-called "in-groups" and "out-groups". This was based on the idea that the leaders for different reasons formed better relationships with some workers than with others. The followers who formed good relationships with the leaders ended up in the "in-group", where they acquired advantages compared to the colleagues in the "out-group". The workers in the "in-group" were usually those who volunteered to take on extra responsibility and did work outside of their regular work description. In recent work, however, the focus has been directed more towards how leaders can succeed in forming good relations with all the workers. This is thought to be the key in building good and healthy working environments. Additionally, LMX studies have revealed that good relationships between the leaders and the followers are

a good indicator of successful organizational output (Northouse 2012). Studies have also shown that good relationships between leaders and subordinates are associated with good performance outcomes (Nahrang et al., 2009).

Currently one-third of all the research done on leadership is about transformational leadership, making it the most popular leadership theory. It revolves around the process of transition involving emotions, ethics, and long-term goals. A transformational leader wants to learn the followers' motives and goals and work towards fulfilling these. The transformational leader wants to help the followers to achieve above expected and often integrate both visionary- and charismatic leadership into the style (Northouse 2012). Burns (1978) was the first scholar to define some leaders as transforming. He called it an engagement between the leader and the follower where a connection was made and thus strengthening the motivation and morality both within the leader and the follower. Due to the inclusion of ethics and emotions, transformational leaders act in a socially accepted way and exercise their leadership following what is assumed as the collective good. Transformational leadership produces results that go beyond the expected. It is more about empowering the followers than to develop the leader itself. Transformational leaders are looked at as a kind of social architects; constructing the path for the followers and help them walk it (Northouse 2012). Increased organizational effectiveness in healthcare can be achieved through encouraging transformational leadership (Top et al., 2013). A significant relationship is found between job satisfaction, transformational leadership, and organizational trust. Strongest were the relationship between transformational leadership and organizational trust. Job satisfaction had strongest relationship to organizational commitment. Organizational trust and job satisfaction together formed the strongest prediction for organizational commitment, in agreement with findings from previous research (Turnely & Feldman 1999; Laschinger, 2008).

1.6.1 Hospitals – professional organizations?

Mintzberg (1979; 1989) operates with configurations to describe different organizations and their accompanying structures and power forces. In his book “The Structuring of Organizations” from 1979 he presented five different configurations, one of them was what he at that time categorized as the Professional *Bureaucracy.* Later, in his book “Mintzberg on Management” from 1989, he changed the name of the configuration to the professional

organization, and added additionally two new configurations to the spectrum making it seven in total. Regardless of the name change, it stills encompassed the same organizational traits. He also continued in his new book to refer to the professional *bureaucracy* as a structural trait of the organization, as it was "bureaucratic without being centralized" (pp. 174). By this he meant that skilled and autonomous professionals carried out the work, but that the organizational environment still had to remain stable so that the skill sets could be performed within a standardized framework (Mintzberg, 1989). In this thesis the term professional *organization* will be used to refer to the mentioned configuration.

According to Mintzbergs' (1989) descriptions, the hospital fits well within the frames of a professional organization. In the professional organization, the workers are highly skilled within their area of competence and work very autonomously; resulting in the knowledge base is located to the ground level. This often results in managerial complications, as disagreements evolve on how and where decisions should be made. The typical professional organization will, for this reason, have developed a system of pigeonholes; defined spaces within which the professionals can work autonomously. These pigeonholes are often crossing formal organizational layers (Mintzberg, 1989).

Another characteristic, and necessity, of the professional organization is that it relies on frameworks for standardization of the professional skills. Particularly is this important in the recruitment process. The organization is dependent on that the workers know their field and that their skills are sufficient. For hospitals, this means that they are fully dependent on the authorities certifying and authorizing health care professionals appropriately. Even the coordination and interaction between the different professionals within the organization are based mainly on these skills. The professionals have learned what to expect from each other, just as they have learned their work tasks, in their professional training. But even strict guidelines cannot standardize humans in the way it can with machines. Skills are indoctrinated, but the application of skills into practice will inevitably always differ to some extent from individual to individual. Thus are professional organizations too complex to be an object of further standardization according to Mintzberg (1989). This is in agreement with Mountford and Webb (2009) stating that the provider organizations in healthcare are dependent on thousands of people making vital decisions hundreds times a day. Thus is it not possible with a "command and control" approach, as it is not doable to control from the top

what needs to be done on the floor. A successful healthcare organization is, therefore, the one that consider all the workers as leaders within their field (Mountford & Webb, 2009).

Neither the techno- structure nor middle-line management are according to Mintzberg (1989) given much focus in the professional organizations, as it is little they can do to coordinate the professionals work actively. Not because professional organizations don't need just as much administration as other organizations, but because the administration in many cases is exercised from the bottom-up. This is seen in hospitals through doctors taking charge over administrative work, or passing it on to a trusted ally. For the support staff, on the other hand, there are no such "democratic" processes managed from the organizational floor, as in these situations the power and knowledge usually are located top-down. Many professional organizations thus have two parallel and administrative hierarchies: the professional democratic bottom-up, and the more machine-like top-down for the support staff (Mintzberg, 1989).

The natural question is thus how to successfully implement - and develop - administration is these organizations? According to Mintzbergs' (1989) point of view the only processes a hospital director can fully administer are the facility management. However, there are also several other important tasks in the organizational environment that needs administration. One example is the handling of situations of disagreement and disturbances in the pigeonhole structure. More than being a perfected solution, the pigeonholing process is a compromise to keep the organization afloat. Thus occur many conflicts from the lack of well-defined areas of responsibilities. In these situations the, often stagnated, professionals need a neutral negotiator to step in and help solve the conflict. Additionally, the administrators serve as a connection between the professionals within the organizations and the outside society (government, patient organizations etc.). This is a task requiring high competencies' as the administrator needs to act as a buffer and negotiator in both directions. The administrators that are able to handle these roles successfully are likely to gain respect and trust from the front-line workers, including the professionals. Succeeding in these areas can thus result in indirect power enabling administration (Mintzberg, 1989).

Mintzberg (1989) later acknowledged that his way of systemizing organizations might not give a complete realistic picture due to the complexity of every organization and its surroundings. He, therefore, introduced an alternative to his previous fixed configurations,

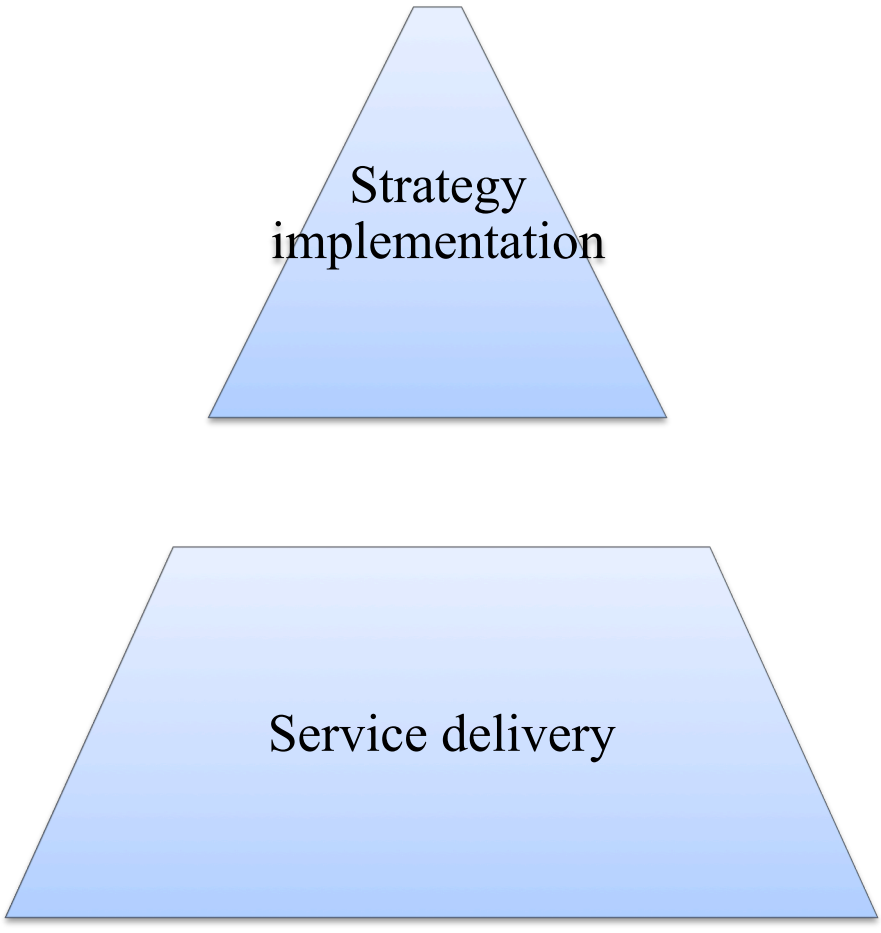
where the organizational categories were put into a pentagon of forces to show how the organizations can diverge in different directions. The assumption was that some organizations might diverge more than other, as not all organizations fit equally good into one of his previously introduced configurations. The hospital organization, however, stands stable as a professional organization as it is clearly organized around a highly skilled working force. Mintzberg (1989), however, argued that even the "good fitters" needed some forces to pull them out of their configuration. If the professional organization experienced no other forces, the focus would be pulled towards pure proficiency, resulting in a state of anarchy among the professionals. This would not be a sustainable state for any organization to endure and thus should the organization also appreciate the forces keeping it stable and "away from the edge". In regards of the professional organization he mentions the machine organization as a potential inflicting configuration due to the continuously increasing demand for efficiency from the surroundings. This reflects the current situation in healthcare well. However, increased standardization – an identifying trait of the machine organization - is exactly what Mintzberg (1989) argued was incompatible to the professional organization when addressing the different configurations. Even so, he also acknowledged that the configurations never could provide a complete picture of reality. He elaborated that true reality never could be fitted into our minds as it would be too big for us to comprehend. Indeed, all operations within our minds can be said to be models or stereotypes, not making them less true. Thus can the theories about configurations still be applicable, even though they do not provide a perfect picture (Mintzberg, 1989).

1.6.2 Discrepancies: de-coupled structure and disconnected hierarchy

Brunsson (1989) provided an explanation for how and why the organizations continuously adapted to the surrounding environment. He explained that when the reality within the organization – organizational norms - and the expectations and requirements imposed by the surrounding environment, did not match, the organization would develop a de-coupled structure as a solution. The result would be the evolving of one formal and one informal organization. It sounds inefficient and is the root of several problems regarding reform and policy changes. However, Brunsson (1989) argued that it is often a necessary action for organizations that wishes to generate coordinated action while also living up to the external expectations. This is based on the assumption that organizations are exposed to an increasing number of unavoidable and inconsistent norms. As Brunsson (1989) repetitively mentioned,

organizations are dependent upon maintaining support from their environment to continue existing.

The power struggle is not only between the internal organizations and the external environments, but also ongoing within the organizations. The professional organization can be said to be a place of what is called a disconnected hierarchy. Best (1999) defines this as the division between those responsible for delivering the services and those actually doing it. In the hospital, the service is the provision of care. The hospital administration, in Norway under the power of the RHAs, sit with the responsibility of providing care to the citizens within the catchment area and to organize it and delegate resources (Ringard et al., 2013). However, highly autonomous clinicians provide the care in the clinic. This fits well with the problems Mintzberg (1989) described with the upside-down organizations where the people in the lower levels of the organizational, the operating core, make the important decisions.



De-coupled hospital structure based on Best (1999)

1.7 Norwegian healthcare system

Norway offers a national healthcare system providing universal coverage to its estimated five million inhabitants. More than 85 percent is publicly funded. It is a two-tiered system where the state has ownership and responsibility for the specialist care, and the municipalities (the local authorities) for primary care. Since the government got ownership of the specialist care in 2002, the responsibility of hospital governance has been delegated to the four regional health authorities (RHAs). The Ministry of Health is responsible for provision of care, and the Minister of Health selects an executive board to lead this work within each RHA. The Regional health authorities make sure that the governmental grants assigned to specialist health care are spent within the given framework. The financing is consisting mainly of two parts; the block funding and the activity based funding. The block funding is divided between the four RHAs by population characteristics capturing needs and expenses to best provide equal service trough out the country. 60% block and 40% activity-based founding finance somatic specialist treatment. The activity-based funding from the central government is calculated by using the DRG-system Other specialist care services are financed through global budgets (Ringard et al., 2013).

Norway spent about 9,5 percent of its GDP on healthcare expenditures in 2010. Compared to the WHOs numbers for the European area this puts Norway as number 16 in regards to spending. However, due to Norways high GDP the real healthcare expenditure is higher than what most other countries operate with. When adjusting the numbers for purchasing power parity (PPP) Norway ranks third in Europe, only beaten by Monaco (38.000 inhabitants) and Luxembourg (543.000 inhabitants) (Ringard et al., 2013; The World Bank, 2013). Looking outside Europe, only the US ranks higher in PPP healthcare expenditure per capita (Ringard et al., 2013). Additionally to already being a “big spender” in regards to healthcare, Norway currently experiences the similar increase in demand for services as most other western countries do. This pressure the system into transformation and changes both in regards of organizing and performance as the policy makers are aiming to achieve cost-containment (Mørland et al., 2010)

1.7.1 The unitary leadership reform

To increase the efficiency of the Norwegian hospital management implementation force, a change the role-structure within the hospital was introduced. The committee behind the Norwegian Official Report of 1997, "The patient first!" ("Pasienten først!") indicated that the management at the time were missing tools and knowledge necessary for making the right decisions, and the willingness to strive towards the goals. Aiming at improving the leaders ability to reach and implement decisions, and to increase the individual leaders sense of responsibility, a new reform introducing uniform leadership to the hospitals was proposed. No formal competencies for the new unitary leaders were put down, except the need to possess sufficient competencies to gain authority among followers. Since the new leader didn't need to be a medical doctor, medical advisors should be appointed when required. Leader/management groups were to secure a multidisciplinary dimension (Sosial- og helsedirektoratet, 1997). When the reform was formally introduced in 2002, it put all healthcare professionals and the same level managerial wise as the doctors (Sveri, 2004). This is a distinct Norwegian phenomenon (Moe, 2006).

The new reform changed a structure that had excised in Norwegian hospitals the past 30 years. The previous dual model was seemingly successful and popular among most of the head doctors and nurses. However, it was not deemed sufficient to keep up with the changes that needed to be done regarding meeting the demands of the 21st century. The unitary leadership reform led to a lot of arguments, both in the surrounding public and within the hospitals. Within the hospitals the argument mainly grounded in a power-struggle between the professions (mainly doctors and nurses). This was evidently due to a perceived threat of the reform leading to demolition of professional lines (Johansen & Gjernberg, 2009).

As the reform was not specific about necessary competencies for the unitary leaders, a lot of room for interpretation was left for the individual hospitals. A result was that all different health care professional could apply for leadership/management positions (Johansen & Gjerberg, 2009). Three years after the reform was implemented the leadership positions on department levels were covered by 65 percent doctors, 30 percent nurses, and 5 percent with another professional background (Gjerberg & Sørensen, 2006).

The Norwegian Medical Association (NMA) was in strong opposition to the introduction of unitary leadership. They argued that the department leader needed to be a medical doctor as the departments' main tasks were to diagnose and to treat patients, thus including competencies other health care professions did not possess. Not only had the department leader "always" been a medical doctor, usually it was also a doctor specialized within the field of the department. This "best among equals" approach in pointing out leaders had been the norm for a long time within the medical profession. It had not been previously questioned as seniority had been considered the primary demand for such a long time (Doolin, 2001).

There have been several theories about why this conflict between the nurses and the doctors evolved so seemingly excessive. Some believed that it was hidden gender conflict (Teig, 2005), others chose to merely focus on the conflict, as it was perceived. Johansen and Gjerberg (2009) wanted to, instead of looking into the reason behind the conflict itself, to look into the differences in the perceptions around the understanding of being a manager and the manager role, and to see if this was affected by latent social roles and professional identity. They built their work on Gouldners (1957) theory. According to this theory, the latent identity is more or less hidden while the manifest identity is made clear. The latent identity can put pressure on the manifest identity in different ways. Johanson and Gjerberg (2009) researched how the professional latent identity affected the manifested manager identity for the department-leaders with different professional backgrounds. One of the evident findings was the difference in previous experience between the nurses and doctors in management positions. Doctors usually had extensive professional experience, while the nurses had more formal management training. This was explained as a possible result of the two professions looking at the managerial position in different ways. Doctors seemed to look at it as a temporary responsibility naturally falling on the experienced and competent within the profession and the nurses as a more permanent change and a career choice. Another finding was that the doctors spent more time doing clinical work than the nurses. However, in total this did not mean the doctors spent significantly less time on the managerial tasks. Rather that they additionally continued doing clinical work on top of their hours working on their managerial tasks, resulting in the doctors having longer working weeks. This was because the doctors meant it was necessary to keep a foot in the clinic to be a good leader. Another important reason for continuing clinical work seemed to be to continue keeping a good recognition among colleagues (Johanson & Gjerberg, 2009). Doolin (2001) found that doctors who choose to go into management positions often were looked at with suspicion

from colleagues. Their behaviors could thus be affected directly by other group members. This match the findings of Mountford and Webb (2009) suggesting that clinicians stepping out from standard clinical paths and into formal leadership often are perceived by their colleagues as having "stepped over to the dark side". Johanson and Gjerberg (2009) found signs of this also among the nurses they interviewed, as they also had experienced disappointment from coworkers when stepping into leader/manager positions.

1.8 Leadership development

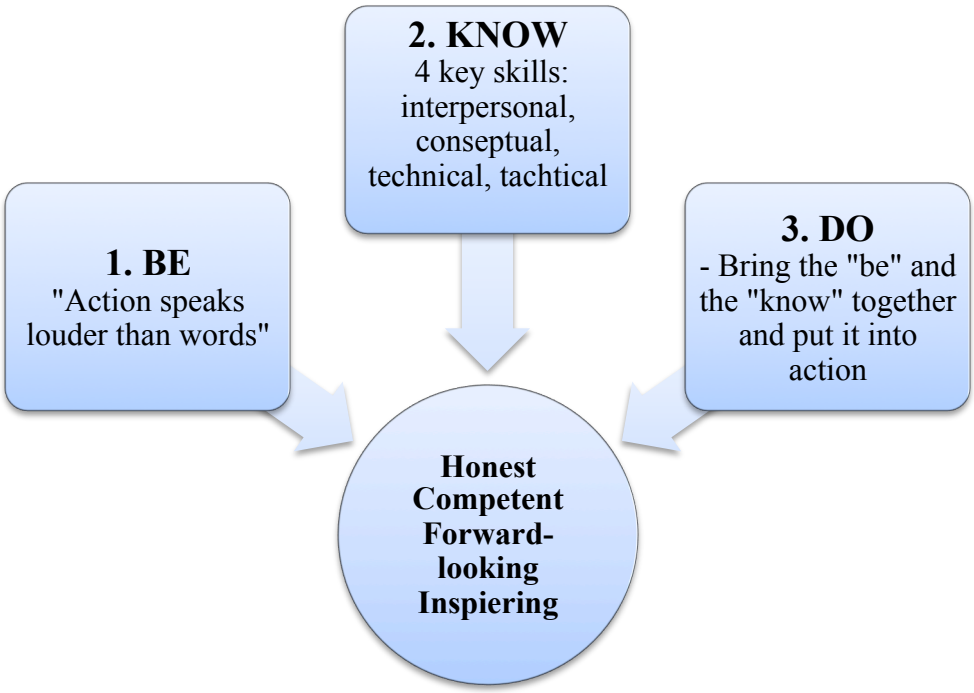
1.8.1 "Be, know, do" – A conceptual framework from the US Army

The US Army has developed an approach to leadership development that has become known as the "be, know, do". Due to its success it has recently also been adapted to fit civilian organizations. The US Army is one of the biggest and most complex organizations in the world. In recent years, they have made themselves remarkable by being acknowledged as the best leader development organization in the US. Their approach is that leadership is something that can be learned, that it is grounded in the individuals' character and values, and that it is about more than management and communication. It is emphasized that it is not enough to merely tell people what to do, but that the followers (soldiers) must have faith in their common goals and willingly follow their leader (Hesselbein & Shinseki, 2004).

According to Hesselbein and Shinseki (2004) the leadership focus is introduced already from training and education. Leadership is something concerning everyone, consequently opposing the traditional common view on military leadership as having a stereotypical "command and control" approach. Contrary the old approach, it is emphasized how important it is for the military to make everybody capable of leadership due to the uncertainty they face in battle. A platoon leader might die in combat, and so might the second in command. However, the platoon cannot stop fighting in the middle of a battle and thus is it vital that every soldier is able of standing up and taking on a leadership responsibility. It is elaborated that the reason the US Army recently has been so successful in their leadership development compared to for example corporate organization is the resources they put into making it happen. While other organizations seem to only be willing to give a certain amount of time and training for an individual to develop leadership qualities, the military are not stopping until they succeed.

This is based on the reason that while other organizations can go “outside their walls” and headhunt external leaders, the military have no choice but to foster them up within the organization. Additionally, because of the high penalty error the army faces with insufficient leadership in a battle situation (brutally measured in lives lost) they cannot afford waiting on the leaders to develop naturally. Thus is the leadership development of highest priority within the army (Hesselbein & Shinseki, 2004).

An extensive study done in the US – involving both government organizations and businesses - identified what characterized a leader that people would want to follow willingly. The answers were found to be consistent throughout the research. The ideal leader was described as honest, competent, forward-looking and inspiring (Kouzes & Posner, 2006). Correlating well with what is aspired to be achieve through successful implementation of the "be, know, do" approach (Hesselbein & Shinseki, 2004).



Leadership competencies based on Hesselbein & Shinseki (2004) and Kouzes & Posner (2006)

Be	Know	Do
• The internal values and attributed shaping the leaders character • Behavior and action needs to be consistent on all levels • Acting as a role model, empowering followers and help them develop own leadership qualities	• Not necessary to know everything, but need to know and master the four key skills: 1) *Interpersonal skills:* coaching, teaching, counseling, motivating, empowering, team-building 2) *Conceptual skills:* think creatively and act analytically, critically and ethically 3) *Technical skills*: the professional skills nessesary to accomplish tasks and funsitons within area of responsibility 4) *Tactical skills:* negotiation, human resources, budgeting etc.	• The ability to put the "be" and the "know" into action: *influence people, accomplish missions, improve organization, solve problems, overcome obstacles, strengthen team, and achieve objectives.* • Use leadership to produce results • Take every chance to improve and seek learning opportunities

Be, know, do; leadership competencies based on Hesselbein & Shinseki (2004)

1.8.2 Developing a functional pipeline

The leadership role in healthcare has expanded as a result of increased organizational complexity (Lee et al., 2010). Good leadership is associated with good organizational outcome, thus making leadership development a vital task for all organizations (Conger & Fulmer, 2003). Lee et al. (2010) argue that the ability to maintain good leadership is endangered of stress and burn-out, and that solving these problems needs thus to be a priority for any organization. Their study of The Alberta Cancer Boards' Leadership Development Initiative (LDI) reviled an establishment of increased social support networks within the participant groups (Lee et al. 2010). Similarly, Stoller (2013) proposed that successful pipeline programs are likely to increase collectiveness and camaraderie between the participants. Lee et al. (2010) found that this factors helped reduce the feeling of isolation in the big organization. Good mentoring programs are also found to improve success of

leadership development programs and decrease incidences of burnout (Lee et al. 2010). Until recently, leadership development in healthcare has mainly focused on individual skills (Frich et al. 2015). Additionally it is characterized by being an intermittent process (Conger & Fulmer, 2003). Efforts to approach, and resolve, these issues can be observed in recent research.

Where organizational succession planning and leadership development previously was considered as two separate operations, it is now time to combine these two according to Conger and Fulmer (2003). This way the organizations will succeed in creating long-term planning and provide security for vital leadership positions. The authors name this succession management, and provide five rules to achieve succession management, and thus a good leadership pipeline. A good leadership pipeline is vital for the healthcare organization (Stoller, 2013). Conger and Fulmer (2003) based their work on the assumption that leadership talents directly affect organizational performance.

Five rules to successful succession management

1 Development focused	Emphasis on the importance of flexibility in the process. Activity oriented, not positions oriented. When successfully achieved the organization will be rewarded with both and up-to-date awareness around required skill sets for different management positions, in addition to offer a system that develops these skills.
2 Identification of Linchpin positions	Where succession planning usually was exercised at the very top in the organization, and leadership development mostly at the mid-level, succession management provides an opportunity to the whole area under one process. It is vital to be ready to "catch" individuals rising in ranks within their division, to provide them with opportunities to further develop their skills. As argued by the authors, to become a successful executive manager, areas from just one field of the organization is not enough.
3 Increase transparency	Succession planning has traditionally been kept hidden to not inhibit people not "on the track" from putting effort into their work. Current organizational environment, however, requires more open communication with employees, as relationship is based on performance rather than seniority. Different approaches and different degrees of transparency need to be adapted to the different types of organizations based on what is more functional.
4 Continuous measurement	The thought behind succession management is to stop thinking of recruitment to management positions as "replacement" but rather see it as a continuous and gradually evolving process. Focus should be kept on different leaders development processes and the speed of their evolvement, to keep an overview over who is currently to follow where and when.

5 Maintain flexibility	Lastly the authors' emphasis that these kinds of systems only are successful when they are perceived as user-friendly and helpful, and when the results they provide actually are good. As there is no one right answer for all organizations, or for individual organizations over longer periods, the process needs continuous evaluation. Especially is this vital is the start-up phase.

Five rules to succession management from Conger and Fulmer (2003)

Based on his research on the Cleveland Clinic Academy, a pioneering organization within healthcare management, Stoller (2013) provides some advice regarding leadership pipelines and program focus. He elaborates that to successfully develop a leadership pipeline it is important to find other competencies than the traditional criteria for healthcare leadership (like clinical skills and scientific accomplishments) when allocating leadership positions. The traditional leadership criteria within healthcare can be used as "threshold competencies" regarding who should be evaluated for different leadership positions. However, other "differentiating competencies" (like technical, team-building, communication, negotiation) should be used to appoint the final leader. Most important among the "differentiating competencies" is the emotional intelligence (Stoller, 2013).

Stoller (2013) additionally suggests that program participants, if possible, should be granted educational credit for the courses. He argues that this would comply good with the medical environment that puts high emphasis on academic achievements. Additionally, he proposes that people from both within and outside the organization should hold the lectures to provide a broad variety of perspectives. Lastly, he highlights the importance of enough time being set aside to participation, so the total workload does not affect commitment negatively.

1.8.3 Program focus' and the effects on organizational outcome

Frich et al. (2015) recently reviewed leadership development programs in healthcare organizations. Their findings show that most current programs build on developing practical individual skills. Emphasis is put on how to provide feedback, team building, conflict resolution and communication. Based on Kirkpatrick' four level evaluation model, the authors developed an approach to compare different programs in regards of assessed outcomes. Referring to experience derived from pervious studies, they widened the model to contain both subjective and objective assessment outcomes (Frich et al. 2015).

Level	Label	Description
Level 1	Reaction	How they felt about the program and satisfaction regarding different components
Level 2A	Knowledge (subjective)	Principles, facts, attitudes and skills learned during or by the end of program, as judged by participant or trainer
Level 2B	Knowledge (objective)	Principles, facts, attitudes and skills learned during or by the end of program, as measured by objective means
Level 3A	Behavior/expertise (subjective)	Changes in on-the-job behavior by participants, or global perceptions by peers or supervisor
Level 3B	Behavior/expertise (objective)	Tangible results that evaluate changed in on-the-job behavior or supervisor rating od observable behaviors
Level 4A	System results/performance (subjective)	Organizational results perceived by respondents and group effectiveness perceived by subordinates
Level 4B	System results/ performance (objective)	Tangible organizational results such as reduced costs, improved quality, and promotions

Levels assessing outcomes of leadership development programs from Frich et al. (2015)

Even though the reviewed programs varied greatly in both duration and content, some characteristics were reoccurring. Most programs had teamwork, conflict management, quality improvement and health policy/strategy on the agenda. Teaching methods also varied, but most of the programs involved plenary lectures and/or group work. Additionally some were found to use project work and simulation exercises. A 360-degree feedback tool was only used in three programs (Frich et al. 2015).

Findings suggested that there was too much focus on the individual practical assignments versus the exercise of the role itself. Most of the programs reviewed were only open for physicians, something the authors attribute to a lack of focus on cooperation and collaboration across different levels of the organization (Frich et al. 2015). Stoller (2013) argue that leadership development is important to all healthcare leaders, both doctors, nurses and those within administrative positions. He thus argues that courses should be held open for all of them. In some situations, however, separating the groups due to different needs might be appropriate (Stoller, 2013).

Most of the programs in Frich et al. (2015) were found to focus on the "know" and the "do" aspects of leadership, and less on the "be". This was evident from the teaching styles mainly consisting of lectures, seminar and some group work. Little time was spent on developmental

relationships (mentors, peer learning and coaching), assignments (action-based learning projects), feedback processes (360-degree) and self-developmental activities.

Findings revealed that the few programs that could document favorable organizational outcomes used multidisciplinary action based learning in combination with plenary groups, group work and seminars. Thus is it suggested that using these multiple methods and multidisciplinary approach is worth the extra time and resources it demands if the aim really is to achieve organizational change (Frich et al. 2015).

SWOT-Analysis for implementation of a leadership development pipeline based on empirical findings

Strengths	**Weaknesses**
• Provides organizations with a long-term way of planning regarding filling leader/management positions (Cogner & Fulmer, 2003) • Secures leaders/managers with good organizational competencies and loyalty to the organization; both associated with success (Miodonski & Hines, 2013; Blouin et al. 2006) • Gives increased continuity in the organization; an axiom with very high relevance for hospitals (Blouin et al. 2006) • The development focus will help the organization to stay up-to-date regarding required skill sets for different management positions (Conger & Fulmer, 2003).	• Implementation is time consuming and will need continuous evaluation (Conger & Fulmer, 2003) • Difficult to defend high spending of money on not-clinical aspects in a publicly funded hospital (Blouin et al. 2006) • Multidisciplinary action based learning that is associated with successful outcome is resource demanding (Frich et al. 2015) • Difficult to measure actual outcome of the course to defend the resource spending (Russel & Scoble, 2003)
Opportunities	**Threats**
• A systematical approach can help discover prominent leader/manager talents within the organization (Conger & Fulmer, 2003). • Increase educational/academic level in workforce by providing course credit in cooperation with an educational institution (Russel & Scoble, 2003; Stoller, 2013). • In many cases necessary resources are already (at least to some extent) available in the organization, they just need to be efficiently coordinated (Miodonski & Hines, 2013) • An internally developed program can better de adopted to meets the organizational culture and goals than an external one (Miodonski & Hines, 2013) • A perceived good leader/manager is associated with improved staff retention, which in turn is associated with economical savings (Duffield et al. 2011)	• Low organizational readiness to change might result in managers not implementing learned skills into their daily work (Lee et. al, 2010) • Unclear expectations from participants' leader might inhibit implementation of new skills (Lee et. al., 2010). • Course participants trying to implement changes, but that fails at achieving results might developed significant skepticism, possibly making them little willing and receptive for further programs (Lee et al., 2010). • Programs that fail to meet the expectations of the participants are in danger of loosing its credibility (Lee et al., 2010). • Participants not being redeemed from their normal workload due to time-pressure might not commit to the course participation (Lee et al. 2010; Stoller, 2013).

SWOT-analysis developed based on empirical findings.

2 Method

This thesis is a qualitative case study. Data was derived through semi-structured interviews and from documents made available by the hospital. The results were assessed against selected applicable theories and existing empirical evidence on the topic.

Qualitative research is, according to Malterud (2001) a good way of exploring topics and experiences within a special setting. The focus is not to identify facts applicable to the wider population, but to gain better or deeper understanding about limited areas. The process consists of systematical collection, organization and interpretation of data in search of explaining a social phenomenon. The phenomenon is studied in their natural context, and the researcher wants to access the experiences as perceived by the individuals (Malterud, 2001).
Case studies are the preferred research strategy when seeking to answer "why" and "how", and to access individuals' perceptions and knowledge (Yin, 2003). There are diverging opinions on how to define a case. In this study, it is chosen to operate with Stakes (1994) definition describing it as an integrated and confined system with behavior patterns and surroundings that makes the phenomenon comprehendible. Unique for cases studies is that it is the only qualitative research method that enables the inclusion of quantitative data (Baxter & Jack, 2008). Thus meeting the statement of Malterud (2001) that qualitative and quantitative research should not be considered as opponents but rather complementary. The broad use of data material is one of the strengths of a case study (Yin, 2003).

In this thesis a qualitative case study was found to be the most appropriate research strategy, as the aim was to gain better understanding of the role perceptions and of the leadership programs as experienced by the participant. The case study approach allowed combining the use of participant interviews with existing survey results and other relevant information available in pursuing to answer the research questions.

The most common problem for novice researchers conducting a case study is to try answering a question that is too broad or too complex. It is thus important to put down clear boundaries concerning place, time and context of the phenomenon (Yin, 2003). This study has accordingly defined a specific group of people at a specific place within a certain time period to avert this issue.

There are several types of case studies, and choosing the right one is important for the quality of the research. Targeting one group of people within one specific environment as done in this thesis is categorized as a holistic single case study. Aiming to describe an intervention in its real-life situation makes it a descriptive study (Yin, 2003). These categorizations are found to correspond well with the research questions of this thesis, thus meeting an important requirement for internal validity (Baxter & Jack, 2008).

2.1 Data sources

2.1.1 Document analysis

The first of the two data fundaments in this thesis is the document analysis. This is a systematic review of written sources aiming at categorizing the content (Grønmo, 2004). This enables the researcher to derive data material relevant for the aim of the research. Yin (2003) highlights the stability of document analysis: when data first is accessed it will continue to stay accessible as long as necessary. Further it is usually very precise and can potentially cover a vide variety of settings and events from different perspectives. A potential weakness with the document analysis is that the preconceptions of the researcher can affect what documents that are utilized (Yin, 2003; Grønmo, 2004). The documents used in this thesis represent both direct and indirect links to the development program in question.

The Human Resources Department at Ahus provided access to internal documents regarding program. This included:

- Invitations and information about the program that were sent out via email
- Descriptions of the program content
- Surveys regarding previous participants satisfaction of the leadership development program

Depending on data made available by the hospital itself might impose a danger to the objectivity of the research as it might be biased. However, the possibility of this was deemed inferior to the possible favors this data could have for the research. As it was not considered

an isolated unit, but rather evaluated together with other documents and the interview data, threats to the studies reliability was not considered significantly high. Additional documents, both specific to the hospital in question and general information concerning leadership in Norwegian hospitals, were identified during the early phases of the research. Discovered mainly through snowballing, certain documents transcended as being of high relevance and thus natural to include. The important utilized sources were:

- **1997:** ***The Norwegian officials report "The patient first!"*** *("Pasienten først!")*
  (Sosial- og helsedepartementet)
- **2001:** ***Uniform leadership in hospitals – Specialist care Act*** *("Enhetlig ledelse i sykehus – Lov om spesialisthelsetjenester*")
  (Helse- og omsorgsdepartementet)
- **2011:** ***Ahus' Strategic Plan for Development 2012-2016*** *("Strategisk utviklingsplan 2012-2016")*
  (Akershus universitetssykehus)
- **2012:** ***The official report: "National platform for leadership in healthcare"***
  ("Nasjonal platform for ledelse i helseforetak")
  (Nasjonal ledelsesutvikling)

Additional data sources to build up under the mentioned documents have been accessed where found necessary and appropriate, for example to gain updated information.

2.1.2 Semi-structured interviews

The second data fundament consists of the interviews conducted with previous participants of the program. Qualitative interviews are, according to Kvale (1996), an appropriate method for gaining insight into peoples' experiences and perceptions. Interviews have become an important tool in qualitative research, both complementary to other sources of data and as a solely mechanism (Knox & Burkard, 2009). The semi-structured interview is the middle ground between the open interview where respondents speak completely freely about a topic and the structured interview where all questions are pre-defined (Dalen, 2004). The advantage of this design is the flexibility it provides concerning unforeseen topics and themes that might come up. It allows spontaneous follow-up questions as well as giving room for

elaboration (Kvale, 1996). An interview guide (see appendix __) was used during the interviews. It contained, following Dalen (2004) the important themes and question identified to enlighten the research questions and consisted of 19 open-ended questions. Topics such as the individual leaders perceptions of their role, the focus of the development program and their expectations were addressed. Seven semi-structured interviews were conducted face-to-face during March 2015. Each interview lasted for between 30 and 45 minutes and was conducted at the respondents' workplace during their working hours for their convenience. They were recorded and later fully transcribed. The interviews were conducted in Norwegian, the mother tongue of both the respondents and the interviewer, and data was translated into English in the analysis process. This approach was chosen as it was assumed that letting respondents talk in their native language would increase the chances of obtaining a rich material.

Recruitment and selection

In the process of recruiting informants to the study, the Department of Human Relations at Ahus was involved due to their position as responsible for the leadership development program. Previous participants from the course that were still working in the same or a similar position were contacted through email with an offer to participate in the study. Eight participants were recruited; however one fell out of the study due to scheduling problems. A strategic sample of informants was attained representing different backgrounds and demographics and thus assumable to represent diverse perceptions and experiences. Following Dalen (2004), it is purposeful to investigate how experiences of one situation can vary between different parties. Malterud (2003) defines a strategic sample as respondents chosen due to the individual knowledge they obtain. The respondents in question represented different parts of the hospital and had different educational background and level. Both male and female leaders participated, and four out of seven had a clinical background.

Participant Profile

Three male and four female mid-level leaders participated in the study. Their mean age was 56,7 years, and the sizes of the departments they were in charge of ranged from consisting of from 10 to 150 employees.

	Cohort		**Background**		
Part.	**1**	**2**	**Physician**	**Other healthcare**	**Non-healthcare**
1	**X**		**X**		
2	**X**			**X**	
3	**X**			**X**	
4	**X**				**X**
5		**X**	**X**		
6		**X**	**X**		
7		**X**			**X**

Interview participant profiles

Analysis of the interviews

Systematic text condensation (STC) was the chosen approach for analyzing the interviews. STC was developed by Malterud (2012) to offer novice researchers a stepwise and manageable approach to this process. Rather than considering it as a theoretically dedicated method, Malterud (2012) explained it as more like a procedure and a strategy. It is inspired by many other already excising methods in qualitative research, particularly on Giorgi's psychological phenomenological analysis. According to Malterud (2012) it provides a way for the novice researcher to achieve intersubjectivity, reflexivity and feasibility together with a reliable level of methodological quality. The phenomenological approach aims at comprehending individuals' perspectives and describing the world as perceived by them (Kvale 1996). The approach was found applicable for analyzing the interview data in this thesis where the aim was to extract the course participants' individual experiences.

In STC data is analyzed trough four steps. First the transcribed data is processed with the aim of getting a good overview and to identify preliminary themes. After reading though the data this led to elleven initial themes. Malterud (2012) suggest that this process should be done

stepwise, during the interview phase, both to make the data more manageable, but also to be able to adjust the interview guide. In this case this was not possible as all the interviews were done within a very limited timeframe. The analysis process was thus not commenced until after all the interviews were done. The next step in STC is to generate the preliminary themes into codes and meaning units. This is done through systematically reviewing the transcribed material again. In this part of the process it is important to be flexible, as achieving good codes is usually not accomplished in the first attempt. The codes should not be based merely on the interview questions, but rather on the previous preconception and the new acquired understanding. What separates STC from Georgis' psychological phenomenological analysis, is that Georgis' method include all data. STC only include parts of the transcribed material into meaning units based on the assumption that not every element from the respondents' answers is relevant to the research (Malterud, 2012).

Through my work process, the eleven preliminary themes condensed into seven meaning units. These were later compromised to six units, following Malteruds (2012) advice on reconsidering codes when frequent double coding appears. As the six meaning units were finalized, the analysis went into the third phase. The data was now restructured to provide the research with organized and functional meanings. Organized into the six units, the process with extracting meaning from it began. The seven interviews were turned into six documents based on the meaning units following Malteruds (2012) thematic cross-case analysis.

Malterud (2012) explains that the last step of the analytical process is to develop a story based on the phenomenon(s) from the empirical data. The text will at this point be given its final design, and the experiences and meanings of different respondents are sewed together into collective answers. In this part, an analysis should also be included where the researcher assesses the findings against already existing knowledge. Malterud (2012) explains that a stepwise approach rewards the researcher as it makes it easier to cut down the material to the essential.

A stepwise approach was found useful in this research, as the transcribed material after seven interviews resulted in 70 pages. Coding these and organizing them into meaning units compromised it to 49 pages. The last step in sharpening the data and transforming the different respondents voices into collective answers compromised it further. Thus making it a manageable sized document of 17 pages when building the results chapter based on the

empirical evidence and previous findings. In this last step, a change was done to the meaning units, as one unit was perceived as too weak to stand on its own. A choice was thus made to categorize information from this unit differently, following Malterud (2012) advice on exercising high flexibility in this stage of the process.

Reflexivity

I have my background from nursing, and I have been working within the hospital organization myself. However, to try to avoid bias and potential ethical dilemmas of mixing the role as a researcher and clinical identity, this was not disclosed to any of the participants ahead of or under the interviews. This choice was following Knox and Burkards' (2009) advice stating that such role conflicts can influence the respondents' answers and compromise the integrity of the data. Additionally, they mention that mixing these roles successfully demands proper training and experience from the interviewer. As this was not the scenario in this case, it was chosen to keep the clinical background hidden during the interviews.

2.1.3 Empirical search

Empirical evidence was obtained through searches conducted in the academic databases PubMed, CINAHL, and Medline. Search items were different combinations of the key terms; "clinical leader", "clinical manager", "clinical management", "mid-level leaders", "leadership", "management", "leader support", "leadership development", "leadership pipeline", "hospital management", "Scandinavia", "Norway". Some articles were also obtained through snowballing and through tips from my supervisor. In the process of selecting articles, the relevance and transferability to a Norwegian hospital setting was emphasized when found necessary. Thus, in studies where the organizational environment played an important factor, studies from other Nordic countries and/or other public national healthcare systems was preferred. For studies concerning the framework, design and effectiveness of different leadership development programs, the requirements to being conducted in transferrable environments were not applied so strictly.

2.2 Ethical and legal aspects

The study was reported to the Internal Data Protection Officer at Ahus (appendix II). The Norwegian Social Science Data Services was also contacted. However, information was provided stating that it was unnecessary to register the research at both agencies.

The recruited participants were informed about the aim of the study, the procedure of undertaking interviews and of how the data was going to be handled and used. This was done both ahead of the interview through an information letter, and then again right before the interview (appendix I). Most of the respondents had participated in similar projects before and expressed a good understanding of the process. Those who participated for the first time were given additionally verbal briefing before the interview about the research process, guidelines and other questions they had. Before starting the interviews they signed a consent form agreeing to the terms and thus giving their informed consent. This procedure builds on Dalens' (2004) explanation of informed consent as being given all information about everything involving participation in the project ahead of the data collection. The interviewer collected the consent forms and stored them safely separate from the data material, securing confidentiality. The respondents were assured that their identity would be kept anonymous, which is especially essential in qualitative research interviews where the respondents meet the researcher face-to-face (Dalen, 2004; Kvale, 1996). In this study, the respondents were asked personal questions about their experiences and opinions about their workplace. It was, therefore, essential to secure that their answers could not be identified as this could potentially affect the relationship with their employers. This is following Kvale (1996), highlighting that participants should not face emotional nor physical harm, or liability issues, as a result of their participation.

The collected data was kept separate from any information that could identify the respondents. The recorded interviews were stored on a separate USB that was never connected to a computer with an active Internet access. The recordings were deleted immediately after being transcribed and were never at any time available for anyone but the researcher. In the transcription process, the interviews were identified with codes only known to the researcher, and all information from the recordings that could be identifying were left out of the transcribed material.

3 Results

3.1 Part I – Description of Ahus and the program

3.1.1 "The Personal Leadership" – A development program for midlevel managers

Akershus University Hospital is one of the most modern hospitals in Europe, and one of the biggest hospitals in Norway, with a total of 954 beds and a staff of 9231 (Akershus universitetssykehus, 2014). In the recent years, it has gone through an extensive transmission phase considering both catchment area and internal structure. In 2011, the hospital's catchment area increased with 160 000 citizens and is today the main provider of specialist healthcare to approximately 500 000 people. In 2011, the hospital developed a strategic plan for the next coming five years. Their patient centered strategies have five main directions; *acute help and treatment to critically ill patients, patient care tracks, securing sufficient capacity and good logistic, further develop preventive care* and *handle inequalities in living conditions and patient composition.* Additionally they also have focus areas within specific treatment areas and strategies regarding research, education of healthcare personnel and idea development. Efficient leadership is pointed out as an important pillar in the strategic work, thus making increased focus on leadership development one of the main tools in reaching their goals. The plan states that increased emphasis on leadership development is to be considered as the basis of holistic development of the organization, and that it should stimulate to reaching the goals within the given time frame (Akershus universitetssykehus, 2011).

In 2011 Ahus started up with an internal development program for their different leadership levels. The programs are arranged by the department of human relations and consist of several modules aiming at achieving increased common understanding of the leader- and the follower-roles. From the program documentation it is understood that the goal is to develop leaders that are motivated, safe and capable of decision-making and that are working towards a common goal. In this project, the focus has been directed towards the program module organized for the mid-level leaders: "The Personal Leadership" ("Det Personlige Lederskapet"). The target group is the department leaders/managers that have other leaders

reporting to them. According to a key informant the program was arranged for the first time in 2013. It builds on the organizations five principles of leadership: *the will to lead, being a guarantor for patient treatment, leeway given though total responsibility, employer responsibility* and *leadership as a system.* Currently two cohorts of mid-level leaders have completed the program, constituting about half of the total group. A new round of the program module started up with the first seminar in April 2015 and is currently going as this thesis is being finished.

Based on the documentation provided by the Human Relation Department at Ahus, the following goals were given for the first two groups:

Goal adjustments from cohort one to cohort two	
Cohort one – goals	Cohort two – goals
• **An understanding of the role** (results created through leadership and through development of other leaders) • Awareness to secure **leadership all the way out** (at the role as a connection between different leadership levels) • **Skills** for the everyday practical tasks as a leader (the role demands active prioritizing of the departments overall resources)	• To **increase the implementation force** among the executive leaders in the organization • **To increase the ability** to exercise the leadership role **in reference to the five principles of good leadership** and expectations to leadership behavior in the organization • To achieve **increased awareness in the role as the connection** between the different leadership levels (secure leadership all the way out and all the way up) • Develop **skills for the everyday practical tasks** as a leader through gaining an increased insight into own strengths and weaknesses, exercise on challenges related to communication and acquire more tools to handle different development processes.

Achievement goals cohort one and cohort two based on documentation from Ahus

The first group had three seminars resulting in a total of 6,5 days within a timeframe of four months. The second group had four seminars each lasting for two days, giving a total of 8 days within a timeframe of eight months.

Course content

Both of the cohorts were introduced to models and theories during the program. Common for both cohorts was the "talent estimation model", Kutter's model for change management and an internal standardized system the hospital uses to develop leaders by challenging them on practical tasks requiring exercise. However, as the change in the goals also imply, the course directed focus more towards concrete skills and measures in cohort two compared to cohort one. This is also indicated in information made available by the human relations department at Ahus regarding the content of the course. Three new models were introduced for the second cohort, namely the 360 degrees feedback system, a model for "situational leadership" and "effective management teams".

Survey results

Presented data was processed from participant satisfaction surveys conducted internally by Ahus. The surveys were conducted electronically after completion of the different seminars. Both teaching methods were not applied in all seminars explaining he difference in available data. The department of Human Resources was responsible for collecting the data. All respondents who had participated in the different seminars were required to answer.

Cohort one

BASIS GROUPS	**Seminar 1**	**Seminar 2**	**Overall tot.**
1 – Very dissatisfied	0,0%	0,0%	**0,0%**
2 – Little satisfied	0,0%	0,0%	**0,0%**
3 – Reasonably satisfied	5,3%	0,0%	**3,1%**
4 – Satisfied	21,0%	30,8%	**25,0%**
5 – Vary satisfied	73,7%	69,2%	**71,9%**

Survey results cohort one; basis groups

- Total respondents were 19 in seminar 1 and 13 in seminar 2.

PLENARY LECTURES	Seminar 1	Seminar 2	Overall tot.
1 – Very dissatisfied	0,0%	0,0%	**0,0%**
2 – Little satisfied	5,6%	0,0%	**3,2%**
3 – Reasonably satisfied	33,2%	23,0%	**29,0%**
4 – Satisfied	33,2%	61,6%	**45,2%**
5 – Vary satisfied	28,0%	15,4%	**22,6%**

Survey results cohort one; plenary groups

• Total respondents were 18 in seminar 1 and 13 in seminar 2.

Cohort two

BASIS GROUPS	Seminar 1	Seminar 2	Seminar 3	Overall tot.
1 – Very dissatisfied	0%	0%	0%	**0,0%**
2 – Little satisfied	0%	0%	0%	**0,0%**
3 – Reasonably satisfied	0%	0%	8,3%	**2,5%**
4 – Satisfied	21,4%	7,2%	25%	**17,5%**
5 – Very satisfied	78,6%	92,8%	66,7%	**80,0%**

Survey results cohort two; basis groups

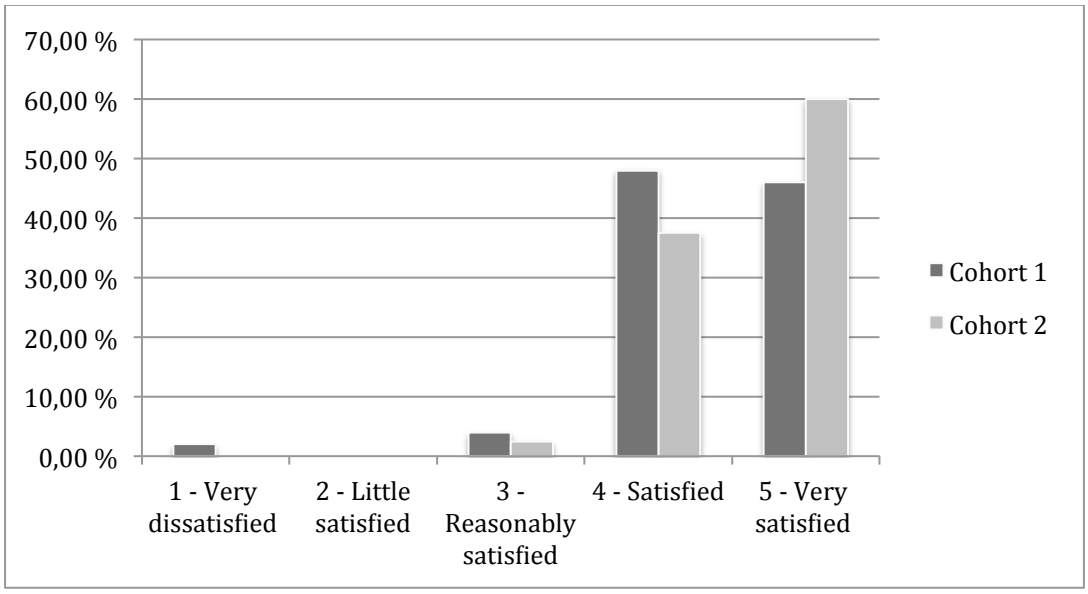
• Total respondents were 14 in seminar 1 and 2, and 12 in seminar 3.

PLENARY LECTURES	Seminar 1	Seminar 2	Overall tot.
1 – Very dissatisfied	0,0%	0,0%	**0,0%**
2 – Little satisfied	0,0%	0,0%	**0,0%**
3 – Reasonably satisfied	7,0%	7,0%	**7,2%**
4 – Satisfied	57,0%	64,0%	**60,7%**
5 – Vary satisfied	36,0%	29,0%	**32,1%**

Survey results cohort two; plenary groups

• Total respondents were 14 in both seminar 1 and 2.

As indicated by the data were participants in both cohorts significantly more satisfied with the basis groups than the plenary groups. There was an overall improvement in participant satisfaction from the first to the second cohort. However, the basis groups continued to be significantly more appreciated by the participants.



Overall satisfaction for both cohorts based on survey data provided by Ahus

3.1.2 Unitary leadership

The Norwegian Officials Report ”The Patient first!” (NOU; ”Pasienten først!”) published nearly 20 years ago made the foundation for the unitary leadership reform that were introduced by law to Norwegian hospitals in 2002 (Sosial- og helsedirektoratet, 1997; Sveri, 2004). The reform stated that:

- Patient centered care was to be achieved through good leadership
- The leader is a leading a organizational unit and not a profession
- The leadership should be unitary
- Leader groups are to secure good multidisciplinary work
- The leader needs to possess competencies provided authority

Leadership qualifications	Academic qualifications
• Personal fitness • Relevant leadership experience • Formal leadership competencies (not an absolute demand)	• Minimum three years of higher healthcare education if leading a patient treating department • In cases where leaders academic qualifications is not sufficient, responsibility for this area need to be set aside to someone else

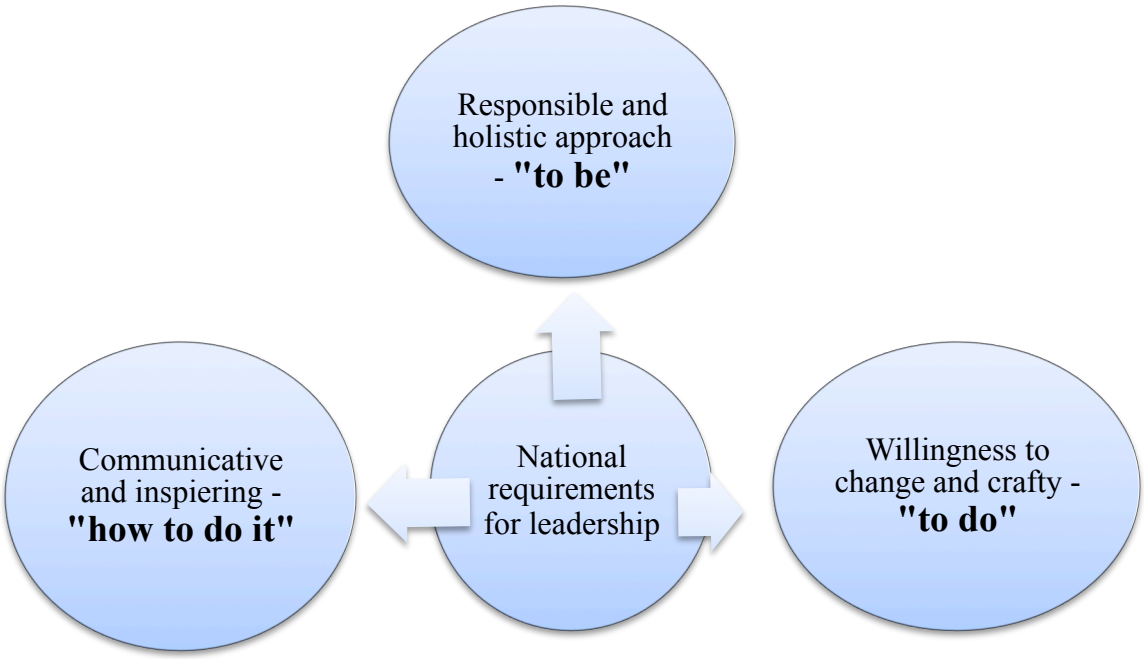
Qualifications for unitary leaders as defined by the Social and Health Department (Sosial- og helsedirektoratet, 1997)

3.1.3 National requirements for leadership

The authors behind the ”National Platform for Leadership Development in Health” presents the following five advises for improvement for leadership in the specialist care:

- Utilize the leadership demands; make them known to all leaders and other staff and develop locally adapted approaches to incorporate the content of the platform.
- The focus on first line leadership development needs to be strengthened. The RHAs are advised on developing common guidelines for training and development.
- Approaches to developing a leadership “lifecycle” needs to be coordinated and further developed. A “lifecycle” including all stages of the leadership carrier should be developed.
- A national framework for the leadership requirements should be developed to make them more comprehendible and easier to implement for the different organizational units.
- The leadership requirements should be incorporated already in the medical- and healthcare science educations.

(Nasjonal ledelsesutvikling, 2012)



National leadership demands based on Nasjonal ledelsesutvikling, 2012

The three first requirements can be argued to be within the leeway of the hospitals, while the last two needs to be considered on a national level.

According to the Norwegian Specialist Care Act § 3-9 the hospitals are required to operate with only one responsible leader at each level. The Ministry can demand certain qualifications through regulations. Additionally, the hospital is required to appoint medical professional advisors when it is considered necessary.

(Helse- og omsorgsdepartmentet, 2001)

3.2 Part II – Participants' views and experiences

The results of the participants' interviews are presented divided into five categories deemed beneficial as a result of the analytical process. The categories are as following: *motivation, self-reflection, expectations and readiness, course content and learning outcome* and *organizational environment and support.*

3.2.1 Motivation

Out of the total of seven respondents, four had actively applied for the leadership/management position they were currently in. Two were motivated through previous participation in their professional union while one was a member of the hospital board at the time of application. The fourth had a wide leadership/management experience from previous positions outside the organization and considered stepping into leadership/management as a natural career step. The three who did not actively apply for the position had been encouraged to take it on by their previous leader and/or coworkers. None of the respondents mentioned social status or financial benefits as motivation for entering the position. Motivational factors listed were such as the ability to contribute, to be a part of the decision-making process and that it would benefit their profession.

Among the respondents who were asked to take on the position, the amount of time taken to decide varied from one hour to several months. The respondent who made the decision within the hour had not been given any prior hints about being asked but did know about the opening as ta member of the hospital board. The respondent had prior experience with leadership/management from outside the organization. The motivation for accepting the position was expressed as a want to be able to influence decision-making and to "put a stamp on a role". The respondent who needed several months to decide had no previous leadership/management experience, and had not considered it as an option at the time. The respondent was not positive towards the opportunity when first being asked, and explained that the amount of time given to allow making a thorough decision was vital for accepting the position in the end. Being in a clinical position when asked, the respondent said that taking on a leadership/management position at first seemed to be premature and scary, as the respondent had imagined staying a clinician for a longer period. The respondent stated:

"My first thought was no, never. Ehm, I thought that now I had to find another place to work, if not I'll be forced into the position […] because neither then nor now is it particularly easy to get leaders […] but then, as I mentioned, I got time to think. And that was important to me when I made my decision, because I'm very passionate about my profession, and I saw a possibility to work with it on a different level and in a different way than through direct patient work"

(Participant 7)

The leaders who actively applied for the positions mainly listed motivational factors such as "socio-political" and "academic ". One saw a hospital facing big restructuring changes and wanted to be useful in that process. Another told about being active in the professional union, and that this experience had made it evident that to be able to get anything to change, it was needed to "excel in the hierarchy". The changes the respondent here referred to were directly related to the organization and management of the respondent's specific profession. The respondent explained:

"What could be done in the position was more important than the position itself"

(Participant 2)

Other identified motivational factors were positive feelings related to being able to get things done, interests in administrating and a desire to have a voice in the development process of the hospital.

When asked what they considered to be important for succeeding in the job, the main part of the answers centered inter-personal skills and coping mechanisms. The ability to handle responsibility was a recurring theme. One respondent explained the leadership position as a place of high pressure from both the upper and lower levels of the organization. To be able to stand in this pressure, it was needed to possess both the will and skills to handle the responsibility. Another respondent explained that the never-ending stream of tasks, make it impossible to have overview all the time. According to this respondent, the key is to accept that full control is not achievable. However, the respondent seemed to be uncertain if this was the key to success or survival. The respondent said:

"... One can not do everything, of course one can follow up on the important stuff, but all the emails and... to accept that some things must be put on hold, I think that is important. And to think that; ok, if something has slipped my attention now people will send a reminder. And not get sleepless and frustrated because one... is never really up-to-date though. That is important... if it is important to succeed as a leader, or if it is important to merely handle it... I don't know."

(Participant 7)

Of the four respondents with a clinical background, three mentioned the importance of their professional skills and the specific academic related to the practice when asked to list factors necessary to succeed in the position. Two of them directly said that some professional experience was an absolute necessity to succeed in the role. The last one limited the explanation to stating that the academics and the professions were given to little focus today:

"... the hospital does not have a focus on being a hospital and the professions/academics any more. I think that it is a bit sad. I think it gets to much... bureaucratized, a little too much formalized, and... like you would think any other organization does it. So I do think the academics gets less focus than it should."

(Participant 1)

Other respondents with a clinical background also mentioned how the leadership/management role had changed in the past couple of years. While it some years ago was enough with extensive clinical experience to step into the position, the same position today demanded a good understanding of for example economy and law. Two clinicians said they would not have chosen to go into the leadership/management position under today's circumstances if they were to make the decision again. One respondent directly stated that: "I am not really interested in leadership the way it is done today", and referred to the way leadership had taken a turn to be more a science of its own.

Another recurrent prerequisite several respondents mentioned as vital to becoming a good leader was something that could be perceived to be some leadership/management x-factor soft-skill. One respondent explained this by giving an example of a highly skilled physician that turned into being a mediocre leader/manager, implying the professional skills alone were

not sufficient to succeed in a leadership/managerial role. Another explained it as a need to be able to make your coworkers enthusiastic, and to help people reach their full potential, to advance and evolve and work purposefully. Another made a comparison between a good functional leader/manager being a "janitor". The statement was based on that the participant experienced the job as mainly "facilitating" for others so they could perform in the best possible way. The respondent explained:

"... you cannot lead people by administrating [...] But, you have to look people in the eyes, make decisions, and talk to them; give them backup if they need it and.. correct them if they need it"

(Participant 4)

3.2.2 Self-reflection

When asked to describe themselves as leaders/managers, most of the respondents listed positive features about their leadership/management style and skills. However, it also became evident that they experienced some personal issues related to the position consisting mainly of problems related to time-pressure. Consequences listed were such as not having enough time to plan and implement strategies, and problems with prioritizing. Two respondents mentioned concerns about being "too quick" in decision-making resulting in either being perceived as overruling or missing out on valuable input from employees.

"... I can miss out on some things if I don't make sure several people gets to say their opinion. I do think I have a good mood, I rarely get grumpy, but... I think I can be perceived as pretty concise, and that I can sometimes seem to cut people off, and thus... and that can be a bit scary for people if they don't know me."

(Participant 7)

Limited time also resulted in that leaders/managers experienced being pushed into prioritizing the visible, and thus measurable, parts of their tasks. These were explained to be mainly the purely administrative tasks and were not the tasks the leaders/managers experienced as the most vital. However, it was perceived as problematic to communicate and defend other prioritizing to the upper management. The result was that other, not so visible but often judged more important, tasks being given little or no priority.

Other issues mentioned were a feeling of loneliness, limited economical resources and maneuvering in the complex organization. In relation to loneliness, it became evident that several of the respondents experienced the manager/leadership position as a place of solitude. The collegial collectivism many of them had experienced in their present positions were gone, and is was a reoccurring worry who they were going to turn to for support and help. As one respondent explained:

"It is a bit lonely sometimes to be a leader also because you have to make decisions, and then sometimes you are unsure if you should use your own leader group in doing this or not."

(Participant 1)

Exposure to continuous economical issues was experienced as difficult for some of the respondents Operating a department under these circumstances could be difficult, both for leaders/managers of clinical departments and facility departments. The following two statements provides evidence for this:

"I'm sitting here with very scarce resources, less than half of what we need, right. And then we work very hard to not let this affect the hospitalized patients, especially not the acute cases. But then it ends up affecting the less sick, you know."

(Participant 2)

"We have been operating with a big loss for so many years now, and, like the upper management says, we need to do better because the buildings will soon need to be maintained […] so we are forced to start operating in zero. So any project now will need to take this into account."

(Participant 4)

Lastly, some of the respondents with clinical backgrounds explained about a perceived conflict often occurring between the professional values and the demands put down by the organization. It was evident that being both a clinician and a leader/manager could be difficult. One respondent elaborated:

"If I were fired for exceeding budget limits, I would be able to live well with that you know… If I were fired for neglecting my professional responsibilities, on the other hand, then I would feel horrible you know… It has something to do with loyalty to the assignment, to the patient and the society. What you are out here to have responsibility for."

(Participant 2)

When the respondents listed their primary tasks in their current position, overseeing the department and facilitating for employees were recurrent answers. Other answers, however, revealed some differences about where in the organizational structure they placed their main area responsibility. While some focused on the responsibility to be a good representative for their employees, others were more focused on their responsibility towards the upper management in regards of implementing measures and achieving results. The majority of those focusing on responsibility for the own department had clinical backgrounds.

3.2.3 Expectations and readiness

Some of the respondents perceived participation in the course program as mandatory, while others described it as an opportunity given through an invitation. A possible explanation can be that the human relations departments approach to this changed between the first and the second cohort. It started out as a solicitation, however currently is it communicated as mandatory for all the leaders to participate.

The expectations the respondents had to the course upfront varied from being very high to non-existent. Respondents with a prior positive attitude (high readiness) described a desire to renew themselves and make sure they were not stuck in their "old ways". They also shared an impression that much had changed to the organizational environment the past years and that they needed develop their knowledge. One of the respondents' had actively searched for previous course participants to listen to their experiences with participating. This contact gave the respondent a positive pre-impression of the course. The respondents more skeptical towards the course listed reasons such as a limited time frame and bad experiences with previous courses. One respondent stated:

"I hadn't really any big expectations for the course. I mean, it is limited what is possible to make happen for a couple of days at a seminar. Because, if you are supposed to change behavior, I think it is something that needs more intensive work over time"
(Participant 4).

Another respondent expressed skepticism whether leadership/management skills was something that could be taught at all. The respondent had been in leadership/management positions for many years and had experienced what the respondent perceived as several failing approaches that had made the respondent make up this mind.

Regardless some skepticism, when the course was finished all respondents except from one was left with a good overall impression. The exception stated that the course "might be of use to some people, but I am not one of them". The respondent wished to tune down that the individual/internal approach to leadership ("being") and instead focus more directed towards the practical issues ("doing"). The respondent did thus not express an overall low readiness to develop competencies; however, the expectations did not match the focus of the course program. The respondent stated:

"I am focused on how we can turn this hospital around to something positive. How can we get out of the problematic situation we are in, both professionally and economically? What can the different departments learn from each other? These kinds of topics were not covered at all, and nobody ever asked me; what do you as a leader need to get help with?"
(Participant 2)

One respondent that expressed a high degree of readiness for the course and that experienced that the expectations were met, also brought the learning actively back to the department after the course ended. The Respondent made use of several of the models taught in the course, and also started up with a project to get evaluations from employees on areas of improvement. Though involving mainly one trusted employee and having regular meetings with this employee the respondent received regular feedback on progress (or the lack of). The respondent did this because, as the respondent stated:

"There is no use of training if nobody see any results."

(Participant 7)

3.2.4 Course content and learning outcome

Most of the respondents stated an overall positive experience from working in interdisciplinary groups. The course consisted of mid-level leaders/managers from all over the hospital organization, ranging from clinical to facility departments. The basis groups were also composed interdisciplinary. There were, however, diverse opinions whether they had the same issues related to their positions or not. The following two statements provide an example:

"And these interdisciplinary groups – sitting there with other leaders with other backgrounds – it proves that we really have a lot of the same issues crossing both departments and professional backgrounds."

(Participant 4)

"I didn't feel like we had the same needs within the group. Rather otherwise; we had some really different needs. We had very different basis of experience, and some had challenges on some areas, while other had it in other places. So it was a complex group."

(Participant 3)

However, the experience of the basis group members having different needs did not necessarily imply an overall negative experience of the group work. Respondent 3 continued with elaborating on how the group work was still rewarding as the aim of the work was focused on the personal rather than purely practical goals. It was also mentioned that this was a rare opportunity to talk to and learn from people working in other parts of the organization. Several respondents valued and appreciated this opportunity to make new connections.

Most of the respondents seemed to agree that the course had been overall useful. There were, however, some differences in opinions regarding what parts had been more useful. Three respondents answered that the work in the basis groups had been most helpful, two answered that the combination of plenary lectures and basis groups was the best option, and one

preferred the plenary lectures alone. One respondent did not find either of the teaching formats optimal.

The work done in the basis groups were mainly focused on developing individual skills as a leader/manager ("being"). The plenary lectures provided additional practical models and tools to handle the leadership/management tasks ("doing"). Thus can it be assumed that individual differences in previous knowledge and experiences on the topics played a role in the perceived usefulness of what was provided in the different teaching format. The statements from two different participants can exemplify this:

"I think the plenary lectures were a bit superficial and not very useful. I do understand the need for having some of these lectures, but it might have been some topics they maybe should have got somebody external to lecture on, or at least though it more through […] I mean, we were mostly leaders/managers with long experience, and then I think that they might adapt some of it a bit more to the group"

(Participant 1)

"I thought it was good. I have taken some of it with me, and I am pretty pleased. But clearly, to me… I heard from some of the others who have more education within the field of leadership/management than I do. I was hungry for everything, you know […] Because I have no training in this from before. But then for the others there might have been a lot of repetition and something that they had heard a hundred times before. But that wasn't me, you know."

(Participant 7)

To what extent, the respondents perceived the course content as useful seemed also to be related to their interest in the focus area of "being" a leader/manager versus "doing" the leadership/management job. Some respondents appreciated being given the opportunity to turn focus inwards towards themselves. Others were much more interested in keeping an out-facing focus on the organization, the problems it was facing and the search for practical solutions.

For some respondents the individual focus approached in the basis groups seemed to cover some kind of "therapeutic" need, as they described it as a good place to talk about and share problems and "ventilate feelings". As one respondent explained:

"It was a place we could ventilate on different topics and thoughts that we usually don't have anyone to… (…) And I felt like it was a collective understanding in the group about this and that we could bring up our struggles."

(Participant 1)

Others said that the basis groups were interesting to a certain point, but that too much time was spent passively listening to other people's feelings and problems without getting any personal gain from it. These respondents expressed a desire for a more practical focus on problem solving ("doing"). As one respondent stated:

"The most useful part was definitely when we came to the point where they gave us some tools. I had felt for a while that "now I am aware of me, now I need some tools, when are they coming?" And then we got some models to help us in the daily work when time catches up with you; how to structure and work with your groups for example."

(Participant 6)

Another respondent wanted a wider practical approach, calling for more focus towards the main issues the hospital organization was facing. The respondent elaborated:

"I would like to discuss things like organizing, economy, cooperation primarily, eh… What each and every one of us could do to help Ahus get up and going. So… A dialog about the hospitals challenges… I would have had a course where we could have looked into what could be done with the situation, instead of having a course about how to learn to live with it. I am not really interested in learning how to live with it."

(Participant 2)

Some respondents pointed out what they perceived as a lack of organizational knowledge among other leaders at their level. One respondent said that several leaders/managers were not aware of what being a leader/manager implied. Particularly was this mentioned in regards

to having the knowledge to operate with the different organizational levels: being both a good representative for the employees and also maintaining the responsibility towards the upper management. One respondent elaborated on the experience as "many leaders here at the hospital miss this basic organizational understanding". The respondent explained this as a direct result of the procedure of recruiting people internally into leadership positions. According to the respondent this was done based on their experience and expertise within the clinical field rather than formal leadership competencies. The respondent said:

> *"I talked to one of the really big leaders/managers here at the hospital, and I said; "you have responsibility for a huge department covering several different fields. That must be a lot of work!" And he replied that no, he didn't really do that kind of work, maybe only 20% of his time were spent being a leader/manager for the department, that was all he had time for. Except from that they would have to manage themselves. And that is a completely normal statement! Many of the really big leaders/managers here at the hospitals have continued operating and seeing patients, whilst putting their responsibilities as leaders aside, and make it into something they do in the evening when they respond to a couple of emails".*
>
> (Participant 5)

None of the respondents perceived that the course had significantly changed them as leaders/managers. However, some of them stated that it had made them more aware of their leadership/manager role and style. For some respondents, the participation in the course had also lead to increased self-confidence, mainly due to positive feedback throughout the course. These respondents underlined the importance of the basis groups' supervisors and how these had played a vital role in helping the group members discover rooms of personal development, motivating and keeping the focus on it.

3.2.5 Organizational environment and support

As several respondents pointed out, the hospital organization has grown increasingly complex during the past couple of decades. The result is that the organization has become what some respondents pinned as increased bureaucratized, and less treatment focused hospital. One respondent elaborated:

"I have seen that things have changed, one must be more… outward looking, and not only focusing on own department… And not get self-centered, but see other roles and other conditions. And the requirements… I think it has changed a lot in the recent years because it is like… A hospital does not keep the focus on being a hospital anymore. It seems. And that makes me a bit sad. I think it is too much bureaucratized, and a bit like… every other company would work. So I think that the professional part gets too little focus (…) it has turned into being a big political game."

(Participant 1)

The organizational expansion has given a raise to several other issues as well. One respondent pointed out that the individuals now tend to disappear into the organizations. Their personal traits and values that lead them into leadership/management in the first place vanish as there is nor room nor time to conserve these traits. The respondent explained that this happened after only a short period in the system and was mainly due to the hospital organization being too focused on systems that they forgot to see the individuals. The respondent explained:

"It is so many systems; we have to respond to reports and all that stuff. So one often ends up removing oneself from being a leader/manager and the focus we originally were set here to have the responsibility for…"

(Participant 6)

Another problem mentioned was related to communication. Working in a complex organization was experienced as difficult when messages and communication needed to cross the different organizational layers. One respondent described it as problematic to direct the organization's focus towards own department as the top management meetings were closed off and that it was hard to get communication through to this level. The mid-level managers/leaders closest leaders above them are supposed to represent them and their department in these meetings. However, several of the respondents pointed out that most of these leaders were over their head in responsibility and had limited or no time to function as their representative in the meetings. It thus seemed to be a potential communicational barrier between the mid-level leaders and the top-management in the organization. One respondent also uttered a concern for the top-management being too focused on answering to the

demands from the health authorities and downplaying the medical and ethical responsibility they have for the citizens in the catchment area. The respondent said that this focus was not in agreement with the values of the working force. The management would continue to struggle getting the clinicians to work with them instead of against them as long as they kept this focus the respondent argued, and stated:

"... in my experience it is easier to get people to join in on quality improvements and new reforms if they are told it is important to secure the quality of patient care. But if you say that the goal is to operate cheaper, it becomes much harder to engage people."

(Participant 2)

When asked about their relationship to their closest leaders above them, the answers diverged from having a good and well functional relationship to not having a relationship at all. Those who perceived the relationship as well functional characterized it by using descriptions such as honest, open and transparent. Having a good relationship was not the same as having a high level of agreement, but rather the ability to accept disagreement, allow open discussions, accept the final decisions made and not keeping hidden agendas. Those who described it as less successful, or even non-existent, described busy leaders not having time/ability to participate in a dialogue. The reason was either that the leaders responsibility area was so big that the mid-level leader/manager were "lost in the process" or a high turnover rate in the position creating instability and uncertainty. While some missed more support from their leaders, others did not expect to receive any. After several years of experience, this had become a norm and was described as unproblematic. One respondent stated:

"... through my experience I have... learned that you have to manage mostly on your own. You can get support in the sense that you... are not stopped in what you wish to do, or that you are given a green light, but the job you have to do yourself"

(Participant 3)

Some respondents missed that their leader took on a mentoring function and positioned themselves as approachable and resource persons. One respondent that indicated room for improvement in the cooperation with the leader experienced an overall lack of trust and inclusion from the upper management.

"What I would have needed would be livable frames and trust, and to be involved in important decision-making processes. Even though the decisions would not go my way, I would like to be more involved, or at least informed, that would have been good."

(Participant 2)

A recurrent issue was problems regarding filing reports, HES (health, environment and safety) and other administrative tasks taking up too much of their time. It was called for increased leadership support and assistance to get this work done was. Also evident was the desire for more peer support, illustrated by the need for a safe place to ventilate thoughts and seeking support without being afraid of "stepping wrong".

Sufficient feedback from their closest leader was associated with whether the respondents perceived the relationship with their leader as well functioning or not. On the topic of giving feedback themselves to their employees, most participants felt that they did a good job but said that there was always room for improvement. Some respondents said that they wished to put feedback into a more standardized system to make sure they provided it enough and sufficiently. One respondent who had already tried this explained:

"I sometimes forget to give feedback, so I have tried to put it into a system (…) until recently I have had a tendency to step in and take over in situations rather than providing good en specific feedback enabling the employee to improve him/herself."

(Participant 6)

One respondent stressed the importance of providing frequent feedback to avoid what the respondent named the "anthill syndrome" (perceiving oneself as equally insignificant as an ant among thousands on the hill). The respondent elaborated that when employees in big organizations start to fell small and unimportant, the result can be a disclaim of organizational responsibility.

"… then it might be very easy to stay at home in bed with that little headache. So it is important to prevent this and to make everyone feel important. Because, yes, we are a huge organization, but we need each and everyone to do their job for us to succeed. And it is important that everybody knows that."

(Participant 4)

4 Discussion

4.1 Data analysis

The material in this thesis comes from seven interviews with midlevel leaders/managers that have previously participated in the leadership development program. Additionally, the Department of Human Resources at Ahus has provided access to results from internal surveys regarding participant satisfaction. In this chapter, I will discuss my findings in the light of existing theories and empirical evidence. It includes a summary of main findings, data analysis divided into three sub-categories, methodological considerations for the research and a conclusion. The research questions seeking to be answered are:

- What data and evaluation results exists about the program?
- How do program participants perceive their leadership role, and what support do they need?
- What do program participants experience as outcomes of participating in the internal leadership development program?
- What are participants' reflections on the program content and structure?

4.1.1 Main findings

Participants were generally satisfied with their performance in the leadership role. There were some diverging assumptions about the prerequisite skills needed to succeed in the role. Clinicians generally put more emphasis on academic competencies, while non-clinicians expressed being more focused on their role as a liaison between the top management and the organization's front line. Some unmet needs for support were uncovered, mainly alluding time constraint, communication barriers and lack of support networks. Participants' accounts revealed a potential conflict between some clinicians' values and the performance targets of the hospital.

The results for the internal evaluation of the program gave an overall impression of participants being satisfied with the program but revealed differences in how they valued various teaching formats. These findings match findings from the interviews indicating that participants preferred the basis groups above the plenary lectures. Participant had different

views on how useful the program was to them. One group perceived the content as one-dimensional and not addressing what they experienced as vital issues while the rest of the participants described the program as "good" and "positive". The difference in satisfaction level can potentially be attributed to the amount of previous experience in the field since a trend was observed that high level of experience correlated with a perceived low yield from the plenary groups. Participants' experiencing high benefit from the work conducted in the basis group showed high interest in turning the focus inward to their own leadership identity. To some extent did they also experience gaining emotional support from other group members and supervisors. It was a trend that the participants who were overall satisfied with the program had troubles with referring to exactly what they liked or what they had learned. They explained the interpersonal approach to leadership as interesting and helpful, but difficult to render in words.

4.1.2 Program design and satisfaction

Regardless of the differences between the participants' prior expectations to the program, the surveys conducted by Ahus indicated that the majority of the participants were overall satisfied with the program. This correlated well with what was found in the interviews; all respondents except one were overall satisfied. However, many participants had difficulties to articulate exactly what they had learned. The data material from Ahus revealed a significant discrepancy in how participants valued the plenary sessions versus the basis groups. The result corresponded well with findings from the interviews where the majority of the participants preferred the basis groups to the lectures. What teaching methods they found most rewarding seemed to have some connection to the amount of previous knowledge and experience acquired within the field. Experienced leaders found the plenary lectures to be somewhat superficial and providing little new information. The satisfaction regarding the basis group seemed to depend on the respondents' willingness and openness to keep a focus on themselves as individuals. A review of the program description revealed that most of the work in the basis groups was activities directed toward the personal leaders and their individual development. The plenary lectures grasped what was perceived as wider topics, like "efficient leadership" and "how to ensure holistic leadership responsibility", besides to functioning as introductory sessions for the basis groups.

Leadership: to be, know or do?

The "Be, know, do" leadership framework emphasizes the importance of approaching leadership as something that is occurring within each individual of a group (Hesselbein & Shinseki, 2004). In their presentation of the framework, Hesselbein and Shinseki (2004) argue that the emphasis on cultivating efficient leadership within the army is so evident due to the high penalty error they face in case of failure. On the battlefield, people might lose their lives if wrongful decisions are made in regards to planning and execution of tasks. It can be argued that the hospital organization might face similarly brutal scenarios as it is also handling life or death situations. The "Be, know, do" model can thus be of interest to the hospital organization, as it shares some common traits with the army. Arguably, both army leaders and healthcare leaders are facing fatal consequences if they are unable to handle their jobs correctly. Furthermore, both organizations seem to fit well within the framework of Mintzbergs (1989) professional organization, characterized by important decisions frequently being made on lower organizational levels by highly competent workers. In the case of the army, Hesselbein and Shinseki (2004) argue that the organizational structure makes the traditional "command-and-control" approach to leadership ineffective. Mountford and Webb (2009) used almost exactly the same word in regards of the healthcare organization, thus strengthening the basis for comparison.

Hesselbein and Shinseki (2004) points out that the reason the US army has become so successful in leadership development, is because they don't have the opportunity many other organizations have to headhunt talents from the outside. They have thus been pushed into prioritizing developing their own leaders. They have accomplished this by setting aside extensive resources to a holistic leadership development approach within the organization, resulting in what we now see as the "Be, know, do" framework. In comparison, the majority of the interview participants in this study were recruited from the inside of the organization. Several researchers have found evidence for leaders recruited internally in the organization having bigger chances for succeeding in the position than leaders recruited from the outside. The rationale behind this is that these leaders know the organizational norms and environment better and that they feel a responsibility for the organization that has invested in them. Additionally, they are believed to benefit from already having several connections within the organization (Blouin et al. 2006; Miodonski & Hines, 2013).

Ahus has named its leadership development program "The Personal Leadership" which naturally implies a focus on leadership within the individual. Even though this approach finds broad support in the "Be, know, do" framework, some voices are calling for a more additional focus on leadership as a process also occurring among the individuals. Fulop and Day (2010) propose a need to start considering leadership as a process that takes place in the entire organization rather than in specific places of the hierarchy. They recognize many of the traditional approaches as being based on the idea to 1) study and fix a person 2) provide the person with a title and 3) make the person responsible of results. They argue that this attitude is too simplistic for the complex healthcare organizations and that no single individual can solve the challenges it is currently facing. This is in agreement with Perry (2003) questioning whether it is efficient to look at the aspects of "self-development", "self-awareness" and "self-empowerment" when the real aim is to solve problems at organizational levels. A change can be made through more focus on teamwork and increased employee empowerment and autonomy according to Fulop and Day (2010). Turning the focus from the individuals towards the organization gives what the authors' pins as a "relational perspective" on leadership as it acknowledges it as something embedded in a process rather than within the individuals. Additionally they highlight the idea that this change to leadership conceptualization might yield a potential positive effect on its acceptance among clinicians. This is based on the hypothesis that clinicians' might perceive leadership as more appealing when it focuses on the collective rather than on placing one individual on a pedestal (Fulop and Day 2010).

Program construction

Stoller (2013) highlights the importance of setting aside enough time for the participants to engage fully in a leadership development program, as the opposite might result in loss of motivation. Mountford and Webb (2009) points out the importance of successfully implementing learning into the work situation, and that this can be achieved through incorporating the participants real life tasks into the course program exercises. This was also found to work as a motivational factor, as participants experienced a direct result of their efforts (Mountford and Webb, 2009). To communicate the aim and goals to the participants early in the process seems to be of high importance. Misadjusted expectations are found to increase the level of cynicism and burnout among participants (Stoller, 2013; Lee et al. 2010). The communicated goals should, however, be realistic to achieve with the program.

Lee et al. (2010) found that that failing expectations might result in a "catch 22" where skepticism for future programs increase. A good idea in regards of increasing the popularity of the course would according to Stoller (2013) be to introduce a system with educational credits. He argues that the medical environment places a high emphasis on academic achievements and that this thus might make participation more appealing to the clinicians. Additionally, he proposes that people from both within and outside the organization should be lecturing to provide a broad variety of perspectives (Stoller, 2013).

Little attention has been given to identifying specific functional program structures within leadership development according to Lee et al. (2010). Through their study of a leadership development initiative (LDI), they found evidence for transformational leadership practices positively influencing the managers' emotional health. Transformational leadership is here referred to as "leading through others" with defined with characteristics such as inspire a shared vision and enable, challenge and encourage employees. Top et al. (2013) additionally found evidence for organizational effectiveness being positively affected by transformational leadership.

Frich et al. (2015) have recently developed a model used to review different leadership development programs in regards to how they assess their outcome. During their work, they noted that the majority of programs focused on the "know" and the "do" aspects of leadership. This was evident from the high incidence lecture being used as teaching methods. Similarly, Fulop and Day (2010) stated that this was a typical characteristic of current leadership development programs. In reference to Frich et al. (2015) it can be argued that even though often observed focus areas like communication, conflict handling, self-management and quality management are important, more focus should be allocated towards "being" a leader. The authors give examples such as developmental relationships, practical assignments, and feedback processes (360-degree feedback tool) to approach and develop the "being" aspect of leadership (Frich et al. 2015).

It is usually a time-consuming process to build a successful leadership development program (Blouin et al. 2006). Looking to Cogner and Fulmer (2003) it is, however, reasonable to believe that it is time well spent as they provided findings indicating that good leadership is associated with good organizational outcome. It should, nonetheless, be noted that organizational outcome is a difficult indicator to measure as argued by Russel and Scoble

(2003). Regarding Ahus' program, outcome measurement seems to be limited to outcome satisfaction among participants. This was measured through surveys that made use of a five-level Likert scale. The questions addressed the participants' experiences of the programs' structure and content in addition to assessing their self-percieved learning. Looking to the model provided by Frich et al. (2015) this corresponds with the levels 1 (reaction), 2A (knowledge) and 3A (behavior/expertise) – all subjective measures. According to Frich et al. (2015) organizational outcome is an important measure when evaluating the effect of leadership development programs. It is, however, often left out, as it looks like to be in the case of Ahus.

Ahus' program description for their mid-level leader development program reveals teaching methods such as plenary lectures, basis groups and (as of cohort two) 360-degree feedback tool. As already stated, the program name implies a focus on the personal sides of the leadership role. This makes it stand out from the majority of programs reviewed by Frich et al. (2015). Ahus uses plenary lectures, a teaching format not optimal to approach the "being" sides of leadership. However, their other teaching formats and the allocation of time between them, indicates that Ahus a long way are approaching their aim in a good way based on the findings by Frich et al. (2015). Information derived from the interviews regarding the work done in the basis groups supported this, as the group work was described as highly interactive. Additionally were the supervisors filling the roles as mentors. These kinds of multidisciplinary action based learning approaches were found to be associated with favorable organizational outcome in the research by Frich et al. (2015)

Implications

As the evidence indicates, leadership is a complicated matter and it is difficult to know how to best address it. Different viewpoints might give the impression of an either-or tradition within the field. It is, however, reasonable to assume that different approaches should be seen as complements in a dynamic system and that leadership occurs both within and among individuals. Ahus has taken a step in the right direction when they started up an internal leadership system. The program in question aims at the midlevel leaders in the organization. However, information from the organization also reveals development programs for additional groups being on the agenda. This might indicate that the organization is in the process of developing a leadership pipeline. This would be following the recommendations stated in the report targeting healthcare leadership on a national level (Nasjonal

ledelsesutvikling, 2012). Stoller (2013) argues that a good leadership pipeline is vital for the healthcare organization. Further evidence for the pipeline can be found in the SWOT-analysis on page 22.

Following what has been uncovered in this chapter, some recommendations can be made to Ahus in regards to improving their leadership program for future cohorts. Firstly, Ahus should continue to keep a focus on the "being" aspect of leadership. The majority of the participants seem to be happy with the program focus, and it is found efficient by empirical research (Mountford & Webb, 2009; Hesselbein & Shinseki, 2004). It should, however, also be considered to additionally focus on the other aspects of "doing" and "knowing" as this is also found to be important (Fulop & Day, 2010; Perry, 2003). It is also important to provide the participants with clear and achievable goals prior to the program, as this has been found to increase participant motivation and decrease problems related to misadjusted expectations resulting in skepticism (Lee et al. 2010; Stoller, 2013). Several participants in this study struggled to render specific examples of what they had learned. This might indicate a need to increase specificity and emphasis of the program goals. Using the 360-degree feedback tool and action-based learning has shown to be efficient in regards to developing the "being" aspect of leadership. Ahus should thus consider increasing the use of these tools in the program (Frich et al. 2015). In regards of approaching the issue with lectures being perceived as superficial and providing little new information, use of external lectures can be a solution as this can bring some new perspectives (Stoller, 2013). A continued focus on improvement is important, as research points out that sufficient and frequent evaluation is vital to make sure the program yields optimal benefit (Conger & Fulmer, 2003). It should be considered to introduce additional assessment tools in addition to the participant surveys. These should aim at measuring objective outcomes, preferably at the organizational level, as this has shown to be an important indicator (Frich et al. 2015).

4.1.3 The leadership role and its requirements

The interviews conducted in this study revealed that motivational factors for stepping into a leadership/management position were mainly such as obtaining the possibility to inflict change to the organization and/or their profession. None of the participants listed factors such as money or status. It was noted that respondents with clinical backgrounds preferred to

direct their loyalty towards their profession and department rather than the organization as a whole. Additionally, was it observed that some clinicians experienced that their professional values did not concur with the goals of the management. The respondents without clinical experience, however, emphasized, in general, a stronger loyalty to the upper management. According to the program description, for cohort two, one of the goals of the program was to "achieve increased awareness in the role as the connection between the different leadership levels". This might indicate that it is a known problem for the organization that their leaders/managers tends to have their loyalty attached to different locations. A tendency was that clinicians' put a high emphasis on academic skills, not only in the clinical environment but also in reference to the leadership positions.

In an effort trying to define a good leader, Stoller (2008) highlights the importance of emotional intelligence. He argues that even though this is a topic often left out of the curriculum, it has shown to be the core of several physician leaders failure. Additionally, an extensive US study by Kouzes and Posner (2006) found high consensus throughout several different organizations in regards of what characterized a leader people would willingly follow. The identified characteristics were: honest, forward-looking, competent and inspiring. According to Hesselbein and Shinseki's (2004) presentation of the "Be, know, do" framework, the competent leader acts as a good role model, has interpersonal, conceptual and tactical skills, and can set these out into action.

What defines a skilled leader?

According to Stoller (2013) can the clinical skills be of high value to the department leader/manager, but it should not be used as a qualification standing on its own. Rather, Stoller (2013) suggests they should be used as threshold competencies for being evaluated when these skills are relevant. This is in agreement with Savic and Robia (2013) who, as a result of their study of mid-level leaders at a Slovenian public hospital, highlighted the importance of the candidates possessing a certain level of skills before entering the position. The authors suggested that the mid-level leaders needed to possess these skills to be able to have any influence on the organizational culture. Similarly, Spehar et al. (2014) found that physicians had great influence power by the virtue of their profession. Their research showed that doctors actively used their medical background to act as a role model for other doctors and exercised influence on the organization. The nurses, however, preferred to hold back on information regarding their professional background. They were instead found to exercise

influence by-proxy though a colleague, preferably a physician. The authors ascribed this difference between the physicians and the nurses to potentially being based on prejudices connected to the professions (Spehar et al. 2014).

Seen in a historic light, it can be understood why physicians, in general, put so high emphasis on academic skills. According to Mintzberg (1989), is standardization of skills one of the basic assumptions of the professional organization to work. Since much of the vital decision-making is done bottom-up, the organizations are dependent on the professionals to have sufficient knowledge in within their field. The healthcare organization is a place where thousands of vital decisions are made every day of people spread throughout the organization (Mountford & Webb, 2009). It is thus understandable that it has evolved a strong tradition of trust being based on academic experience and competencies. After the introduction of unitary management, however, there is no longer any formal organizational requirement to have medical department lead by physicians (Johansen, 2009). The positions are now opened up for other clinical backgrounds as well; although there are some cases might be required to have medical advisors (Sosial- og helsedepartementet, 1997; Helse- og omsorgsdepartementet, 2001). Thus is it now established a new system for safeguarding replacing the old tradition. The skepticism from the physicians might indicate, however, that this new system has yet to earn their full trust. A change in the clinician's perceptions might be challenging due to their strongly integrated professional identity. According to Schein (1978) this identity is defined as a relatively permanent set of values, experiences, attitudes, beliefs and motives.

Roots of motivation and identity

When discussing clinicians' way into management, it is natural to take a further look at Mintzberg (1989). He elaborates that the skilled and autonomous employees in the professional organization are used to taking charge and responsibility and that they regularly step into strategic positions to maintain control. Often are these positions in the middle management, placing them in proximity to both the fellow clinicians and the upper management. Thus is, according to Mintzberg (1989), the middle management in the professional organization in reality neutralized as it is usually controlled by the professional either directly or indirectly. Without a functional middle management, strategy implementation can be a difficult job for the top management as the like of cooperation is compromised. This makes the hospital organization a typical disconnected hierarchy where

service delivery is conducted independently from those responsible for service provision (Best, 1999). Mintzberg (1989) further explain that the professional organization possibly can be a place of two parallel power hierarchies. In addition to the professional bottom-up there are indications for also existing a top-down structure in regards to support and facility staff. If this is the case, then the degree of real influence power between the clinical and the non-clinical group might be high. This can explain why the two different groups of leaders/managers sometimes exhibit differences, for example in regards to where they place their loyalty.

It has been observed disagreements between the norms and values of the clinicians and the aims of the organization. An article by Currie (1999), evaluating a leadership development program introduced to the British NHS, noted that the general management was highly unsuccessful in their way of approaching the clinicians due to their focus on cost-cutting and industrial models. The research found that the clinicians were angered by the lack of a focus on the care and the treatment of the patients, as this is the clinicians' mind were the main tasks of the hospital.

In reference to motivational factors, Spehar et al. (2012) observed an absence of financial motives among clinical leaders/managers entering leadership/management positions. They pointed out that for physicians meant stepping over into a leader/management position usually a decrease in their salary. The study suggested that many clinicians entered into leadership/management because they believed it could positively benefit their profession. The task was to some extent presented as a burden the followed the responsibility of the profession (Spehar et al. 2012). This can be seen in the light of the previous management structure of Norwegian hospitals, where the norm was that "the best among equals" was appointed as the leader/manager within each field (Johansen, 2009). As previously stated, this was replaced with unitary management in 2001 to increase efficiency of hospital management (Sosial- og helsedirektoratet, 1997; Sveri, 2004). Attitudes similar to what have been uncovered here indicate that even though this reform has been implemented a long time "on paper", the internal attitudes at the hospital has not necessarily changed to the same extent. This complies with what Brunsson (1989) characterized as de-coupling; when the external demands an organization is exposed to does not fit the internal norms, the organization develops a de-coupled structure with one formal and one informal organization. According to Brunsson (1989) this is a relatively normal defense mechanism in today's

organizations, as they continue being exposed to an increasing amount of demands that are both unavoidable and inconsistent.

One study found evidence indicating that the clinical leaders, physicians, maintained an egoistic point of view when entering a leadership/management position. Physicians that kept the focus exclusively on their own department and showed little effort to use their influence horizontally in the organization exemplified this. The authors noted that this failed cooperation across departments could result in clinical leaders developing informal routes and individual solutions when maneuvering in the organization. This was presented as a potential threat to the top management and the organization as a whole as it could compromise the formal management structure in the hospital (Spehar et al. 2014). Also, other empirical data revealed issues regarding how clinical leaders/manager – mainly physicians – placed their loyalty. Gjerbergs (2009) study on differences between physicians versus nurses in leadership/management roles, found that while nurses mainly perceived the leader/manager role as stepping into a new profession, the physicians brought with them their clinical identity into the new role. According to Gouldners (1957) theory, can the physicians here be categorized as cosmopolitans, meaning they ascribe their identity to something external (the medical profession) and not the place they are (their specific position in the hospital organization). This means that they continue to hold on to their clinical identity regardless what position they are put in. Nurses are in this theory categorized as locals. They tend to place higher significance on their current position than on their professional background. According to Johansen and Gjerberg (2009) this difference can be potentially be ascribed to the differences in the education. In Norway, it is required to accomplish a three-year bachelor degree to become a nurse while medical doctors must study for six years. Additionally, a specialization within nursing takes one to two years while it for a medical doctor can take another five to six years (Johansen & Gjerberg, 2009). Thus is it clear that the physicians have invested more than the nurses to get to where they are, and this might be a natural explanation for why they are more attached to their profession.

Several authors have argued that having clinicians in leadership positions is essential for the hospital organization due to their ability to affect the organization (Degeling & Carr, 2004; Degeling et al., 2003). However, these clinicians often find themselves in a squeeze between improving performance, reaching set targets and their professional role, values and identity (Currie, 1999; Hoque et al. 2004). These hybrid managers might stand in some of the most

difficult scenarios found in any organization today (Fulop & Day, 2010). Due to the hospitals structure being what Mintzberg (1989) characterized a professional organization, there are some irregularities regarding the managerial lines in the organization. The management reform introduced almost 15 years ago seem not yet to be fully acknowledged in the organization. This might specially apply to physicians placing a high value on medical skills. The informal authority has evidently a strong influence in the hospital organization, sometimes maybe even stronger than formal authority. Thus poses Hoffman (2002) a valid question; is the formal manager indeed is the real manager of the organization? As long as physicians place their loyalty and trust within their profession rather than in the organization, this seems to be a difficult pattern to change.

Implications

One identified conflict was that clinicians, particularly physicians, have a tendency to be reluctant in reconciling with changes occurring in the hospital organization regarding management structure. As these clinicians represent an influential group in the hospital, it is vital to get them "on board" to succeed when changes are being implemented (Spehar et al. 2014; Degeling & Carr, 2004). As a group, the clinicians carry a long tradition, and for many years they had the hospitals to themselves without the interference of "bureaucrats" (Mintzberg, 1989). Their professional identity strives naturally towards putting patients in the focus, as their education has been focusing on this. Although it might sound like a positive property, when it becomes an obstacle for the organizational operation it might be time to take action.

When trying to improve the communication flow, is it important to keep in mind what originally motivated the clinicians to spend their working life doing what they do. Findings suggest that money is not an incentive, and this is also identified by other researchers (Spehar et al. 2012). Since the clinicians as a group do not seem to prioritize finances, implementations of new reforms should thus not be justified in these terms when presented for this group. Clinician language seems to center around patients and treatment, thus should goals and achievements be presented in these terms. Additionally, when communicating with this group, for example in regards of changing habits or adverse actions, it should be kept in mind that clinicians, in general, are rational individuals. They are used to base their work on evidence-based practices, it is thus necessary to provide sufficient information regarding why the changes is being done. According to Mintzberg (1989) are the clinicians, as a group, used

to be in charge, and it is thus also important to include them in the decision-making processes leading to future changes and implementations. Findings from this study suggest that this is requested by the mid-level leaders, even in situations where it is only to gain information and not to inflict change. Transparency seems to be of evident importance and should be given focus.

4.1.4 Leading in the organizational environment

Ahus' development program is a direct response to the nationwide demand for increased focus on leadership in the specialist health care (Nasjonal Ledelsesutvikling, 2012). It is also an important tool in achieving their own specific goals presented in their current strategic plan (Akerhus universitetssykehus, 2011). The invitations to participate in the development program were distributed to the mid-level leaders/managers and their leaders via email. Through the participant interviews, it became evident that it existed a disagreement among the participants whether the course was mandatory or not. A conversation with the Department of Human Relations confirmed that the course was currently mandatory, but that it might not have been communicated this way from the beginning. Since the respondents in this study origin from two different cohorts, this change to the participation requirements is thus a natural explanation for these diverging perceptions.

According to the documentation provided by Ahus, the participants' from both cohort one and cohort two were required to participate in a meeting with their leaders prior to the start-up of the program. The aim of these meetings was to identify personal goals for the participants' upon starting the program. Additionally, this was intended to secure that the participants' leaders were also involved in the process, as they handled the follow-up of the participants after the completion of the program. Through the interviews with the participants, information surfaced pointing in the direction that not all the mid-level leaders/managers had a functional relationship to their closest leader. A couple was happy with the relationship, but several experienced their leader as more absent and/or unavailable that they preferred. One participant even went so far as saying the relationship was non-existent. A reoccurring tendency was that the respondents requested more transparency and openness from the upper management. Participants uttered that even in situations where there would be nothing they

could do to change the outcome would they still prefer to be informed. Being kept in the dark or only told what they perceived as half-truths increased skepticism to the hospital management according to the respondents themselves.

Communication and support

The interview results revealed that several of the participants experienced communication and collaboration within the organization as difficult. Time constraint was also an evident problem. Too much emphasis on administrative work made the leaders question their leadership practice. It was called for a safe place to turn to for advice, and to ventilate thoughts and ideas. Some wanted to improve the relationship with their leader and have this person function as a mentor; others would prefer a peer-support network. According to the report by the National Leadership Development (2012), it is a known issue that leaders can experience their position as lonely and miss the previous collegial network. It is pointed out that systems exist for providing advice and guidance for the professionals working in the clinic, and those similar systems are not present for the leaders. According to the report several regions is currently developing a mentor program, but it is pointed out that the support the leaders find most valuable is the from their own leader group (Nasjonal ledelsesutvikling, 2012).

Blouin et al. (2006) elaborate on how good relationships between within the leaders are a vital part of good succession planning. Succession planning is here referred to as a bigger part of the leadership pipeline process, and not merely finding the next CEO. It was highlighted that efficient relationships should result in both formal and informal mentoring/coaching. This will provide the needed continuance in feedback, and the casual daily coaching is pointed out as important as the midyear and annual performance reviews (Blouin, 2006). Research has shown that effective mentoring can predict an individual's academic success. Evidence from especially the business community points towards multiple mentors equaling more success. In regards of the healthcare organization, it is natural to believe that the same will apply. Due to the organizations complexity, having diverse mentors are likely to be beneficial (Tsen et al. 2012).

Inefficient communication between the leadership levels does not only inhibit a potential beneficial succession planning, but it can also result in stagnating vital information flow. Fagerström and Salmela (2010) found that as many as one-third of the mid-level leaders in a

Finnish hospital were unaware of the reasoning behind reform changes. They had thus no proper basis for understanding the reasoning behind implemented changes. The researchers found that this lacking ability to convey information resulted in decreased organizational commitment and increased skepticism. It is no doubt a significant problem when the organization is not even can reach out communication-wise to mid-level leaders/managers, as these positions are vital links between the upper management and the workers. And it is a definite/actual problem as the report from the National Leadership Development (2012) uncovered; numerous of conversations with hospital leaders and managers spoke clearly. Resolutions from the top are unable to reach down to the main workforce.

In regards to organizational change, Lee et al. (2010) found evidence for the role modeling being an important factor. Their evidence suggests that how leaders act and react in regards to reform changes have a big influence on how the workers perceive the reform change. Already several mentioned characteristics of the professional organization complicated the work regarding implementing changes from the top. The professionals are usually not very susceptible to these changes as the administrative management has little influence on them according to Mintzberg (1989). Additionally, some changes might overall be inconsistent with the internal norms and performance of already existing tasks. In the last scenario, the organization is pushed into handling tasks on two different levels, the formal and the informal, meaning they acknowledge it in theory but ignore it in reality (Brunson, 1989). The report from the National Leadership Development (2012) similarly provide information from numerous of conversations with hospital leaders and managers; resolutions from the top are unable to reach the main workforce.

A high pace, increasing demands for multitasking combined with high responsibility, time pressure, and limited resources was found to not only affect the leaders working life but also their personal life. As it was assumed that little imminent action could be taken to change the role itself, some researchers instead looked into how this extremeness could be turned into a positive extreme. The researchers found a need to relieve the leaders from their administrative workload, so they could focus energy on other imminent tasks demanding their attention (Buchanan et al. 2013). This is in agreement with the wishes of several of the participants in this study that expressed a frustration over being "locked" by all the administrative tasks that has been given priority from the upper management. They felt these tasks were keeping them away from performing their leader role as they would like to do.

The numerous reforms in health care affect both the organization and the people within them. Especially affected are those who must lead the change. Mid-level leaders are rarely involved in introducing organizational change. However, these are often the ones being given the most challenging jobs in implementing it (Fagerstrôm & Salmela, 2010). According to a study by Spehar et al. (2014) clinicians, especially doctors, are having troubles to juggle the roles as a professional combined with a leader/manager. They are observed to cling on to their professional identity, as this is what provides their work with meaning.

A UK study by Buchnan et al. (2013) found that 75 percent of mid-level managers had jobs that could be defined as extreme. These extreme jobs were associated with fatigue and burnout leading to increased incidents of error. Since many of these leaders/managers are so-called hybrid managers, still working in the clinical, this is especially disturbing. Through his studies of the LDI at the Cleveland Clinic, Stoller (2013) found that strong social connections and a place to share ideas and to learn reduced the feeling of isolation often experienced by managers. Creating such arenas are important for the current managers, but it was also highlighted how it could serve the purpose of recruitments as well (Stoller, 2013).

Implications

Empirical evidence indicates that several areas like succession planning, information flow and change implementations can potentially be affected negatively by suboptimal communication (Fagerström & Salmela, 2010; Blouin et al., 2006; Lee et al., 2010). Thus seems it reasonable to highlight the importance of a focus on this area. Through the interviews, it became evident that some of the participants experienced it as challenging to communicate with their closest leader. This has additionally shown to be associated with low implementation success following development programs (Lee et al. 2010). Focus should be directed towards improving communication and cooperation between the mid-level leaders and their leaders. Providing friendly arenas where different leadership levels can meet can be a positive contribution in regards to this. Communication should be encouraged as a focus area for all levels of the organization. Potential expenses this might inflict on the organization should be measured and compared to losses occurring due to the potential mentioned outcomes resulting from suboptimal communication.

Additionally, due to an evidently heavy working load, it should be evaluated if the leaders can be redeemed of some tasks that not necessarily must be undertaken by them personally. Hereunder especially administrative work should be taken into consideration. In addition to redeem more time for other leader/manager responsibilities of vital importance, it is believed to affect the leaders emotional health positively (Stoller, 2013, Buchanan et al. 2013). It is an evident need for arenas where the leaders can meet and exchange experiences, seek support and build networks with other leaders. This has shown to be important for the leaders emotional wellbeing and productivity (Stoller, 2013). It should be looked into if this can be connected with the development programs, or be built on other arenas. This event(s) should be based on the leaders own terms. It might thus be an idea to approach the leaders themselves in regards to seeking input on ideas and implementation.

4.2 Methodological considerations

As previously mentioned, it was chosen to keep the researchers identity hidden during the conduction of the interviews. However, the researchers background will still be able to affect the study. According to Malterud (2001), do our backgrounds always an effect on research, both regarding approach and analysis. Due to my background from nursing and working in a hospital, I naturally carry some preconceptions related to this topic. This might have affected my analytical process in regards of what was emphasized, as I might have found topics relating to own experiences more interesting. I have, however, been aware of this issue during the process and strived to give all relevant areas equal attention. It is a potential weakness that I have been the only researcher in the analytical process and thus missed out on the benefits of using researcher triangulation. I have, however, had the opportunity to discuss the analysis with my supervisor who questioned and challenged my interpretations and assumptions. I have thus not been fully alone in the process, giving the data increased credibility.

The interviews revealed that the mid-level leaders possessed diverging experiences and perceptions. Many relevant findings in regards to the research questions indicate that the chosen research design was appropriate. The combination of the survey data and the interviews gave a rich picture of one small groups' experiences related to the program. It

should nevertheless be noted that the participant selection was limited (n=7) and that each participant only was interviewed once. It should thus be assumed that there still are uncovered topics related to the field.

This study provides data on how one group experienced the program. Combined and supported by survey data from all previous participants, it is assumable that this study provides relevant evidence the hospital can make use of in their future program cohorts. It should, however, be exercised caution in regards of transferring findings from this study to other situations due to its limitations in relation of size and participant selection. Nevertheless, it might provide useful information in regards to further study topics in the field.

5 Conclusion

The survey data from Ahus consisted of scores indicating participants' satisfaction and self-assessed benefit. It was collected through online questionnaires, based on a five-level Likert scale. Together with the interviews these data provided evidence for participants being all over satisfied with the program. It became evident during the interviews that several respondents struggled to render on the concrete usefulness of the program, indicating a need to concretize the learning to increase chances of successful implementation. To successfully measure the outcome of the program, it is advised to introduce assessment tools on an organizational level. The participants perceived themselves as competent in their roles, but the hybrid leaders elaborated on conflicts between the role of a leader/manager and a clinician. Old traditions seem to remain within some physicians' attitudes, hindering optimal implementation of new reforms. Mintzberg (1989) gives several suggestions to how the hospital organization, as a professional organization, is distinctive from other organizations. Empirical data support his theories and a show that approaches to implement measures often fail, as the justifications are inconsistent with the values of the mid-level leaders. Communication strategies should thus be better adapted to the receiver array. The mid-level leaders seldom have a say in implementing new strategies but usually end up with big responsibility in regards to the actual implementation. Based on wishes from the leaders themselves, it should thus be considered to involve them more in the process.

Participants preferred the basis groups to the plenary lectures. Most of them were happy with the specific focus on the personal leadership. However, a little group perceived this approach as misplaced in regards of the hospitals current actual issues. The empirical data supported the programs' approach, but there were however also indications on other approaches being equally useful. The possibility of merging in more approaches should thus be considered. Together with continuous and sufficient evaluation, this is believed to increase program success measured in both organizational and individual outcome. Furthermore, the interviews indicated that the mid-level leaders experience excessive time-pressure. Some also perceived the leader/manager role as a place of solitude. A need for further support was identified, both in regards of relieving the leaders for selected work tasks and facilitating for peer-support networks.

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Appendix

I: Participant information and consent form

Informasjon og samtykkeerklæring

(Forespørsel om deltakelse i forskningsprosjekt)

"Lederutvikling i helsevesenet; en case-studie av mellomledere ved Akershus universitetssykehus"

Bakgrunn og formål
Formålet med denne studien er å undersøke hvordan mellomledere ved Akershus universitetssykehus (Ahus) oppfatter sin lederrolle og hvilke erfaringer de har med å delta i internt lederutviklingsprogram. Ambisjonen med studien er å kunne fremskaffe kunnskap som kan være nyttig i uvikling av fremtidige utviklingsprogram for ledere. Studien er en masteroppgave som skrives ved Avdeling for helseledelse og helseøkonomi, Institutt for helse og samfunn, Universitetet i Oslo.
Aktuelle deltakere i studien er tidligere deltakere fra internt lederutviklingsprogram ved Ahus, med ulike yrkesbakgrunner og fra ulike avdelinger. Studien gjennomføres i samarbeid med HR-avdelingen ved Ahus.

Hva innebærer deltakelse i studien?
Studien innebærer et individuelt intervju bestående av 15-20 spørsmål om egen oppfattelse av lederrollen, lederoppgaver og erfaringer fra deltakelse på intern lederskole. Digital opptaker vil bli benyttet under intervjuene. Intervjuene vil ta mellom 30-45 minutter.

Hva skjer med informasjonen om deg?
Alle personopplysninger vil bli behandlet konfidensielt. Lydopptak fra intervjuene vil bli slettet umiddelbart etter opptakene er bearbeidet til skriftlig materiale. Transkriberte intervjuer vil avidentifiseres, for eksempel ved at avdelingstilhørighet slettes. Kun student og veileder vil ha tilgang til transkriberte intervjuer. Personopplysninger vil bli lagret adskilt fra øvrige data, og koblingsnøkkelen mellom dette vil kun være kjent for student.
I analysen av materialet vil vi være opptatt av felles tematikk og vil i presentasjon av funn ikke oppgi avdelingstilhørighet eller andre opplysninger som gjør det mulig å identifisere enkelte deltakere.

Prosjektet skal etter planen avsluttes 31.12. 2015.

Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli slettet. Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med Hege Sjøvik (student) på telefon

95947702 (t.o.m 20.03.15) og +43 660 5987189 (f.o.m 21.03.15)/ *hege.sjovik@gmail.com* eller Jan Frich (veileder) på telefon 48057813/ *jan.frich@medisin.uio.no*.

Studien er meldt til internt personvernombud ved Akershus universitetssykehus.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta.

(Signert av prosjektdeltaker

II: Approval for study from Internal Data Protection Officer at Ahus

Enhet for Administrasjon og Forskningsstøtte
Akershus universitetssykehus HF

Forenklet meldeskjema for student/mastergradsprosjekter som medfører behandling av personopplysninger som er melde- eller konsesjonspliktig i henhold til personopplysningsloven med forskrifter.

For at forenklet melding skal kunne benyttes må man kunne krysse av på samtlige punkter nedenfor. Dersom ett av utsagnene ikke stemmer overens med prosjektets formål og gjennomføring, så må fullstendig melding sendes til personvernombudet. Prosjektet må da ha egen tilråding fra personvernombudet.

Utfylt skjema sendes til personvern@ahus.no sammen med informasjonsskriv og prosjektbeskrivelse.

Når personvernombudet har kvittert for mottatt melding, kan prosjektet starte under forutsetning av at man har innhentet godkjenning fra avdelingsleder.

Saksnr. 15-003

1 INFORMASJON OM ANSVARLIG FOR PROSJEKTET	
A. PROSJEKTLEDER	
Navn og stilling (VEILEDER) Jan Frich, professor ved UiO Navn (STUDENT) Hege Sjøvik	Klinikk/avdeling hvor prosjektet gjennomføres: Gjennomføres i samarbeid med HR-enheten ved Ahus (kontakt opp mot Jan Inge Pettersen og Marit Aamodt)
Telefonnummer (STUDENT): 95947702	E-postadresse (STUDENT OG VEILEDER): jan.frich@medisin.uio.no hege.sjovik@gmail.com
B. ANSVARLIG VIRKSOMHET	
Navn på høgskolen / universitetet som er ansvarlig for prosjektet Universitetet i Oslo	
2 PROSJEKTETS NAVN/TITTEL	
Leadership development in health care: a case study of midlevel managers at Akerhus University Hospital	
3 PROSJEKTETS FORMÅL	
Ambisjonen med prosjektet er å kunne gi kunnskap om lederes forståelse av egen rolle og gi innsikter som kan brukes til utvikling av programmer for å utvikle ledere ved Ahus.	
4 PROSJEKTETS VARIGHET	
Studiestart og studieslutt (dd.mm.åååå): 15.02.2015-15.06.2015	
5 ERKLÆRING OM PROSJEKTET	
Avsender erklærer at følgende utsagn er korrekte (sett kryss): X En høgskole / et universitet i Norge er databehandlingsansvarlig for prosjektet X Prosjektet er ikke søknadspliktig til REK. Veileder har vurdert spørsmålet. X Prosjektet meldes til NSD X Deltagerne samtykker skriftlig X Samtykket vil utformes i tråd med vilkårene i NSDs tilrådning X Deltagerne er kun ansatte ved sykehuset X Det registreres ingen informasjon om deltagernes helse X Det registreres ingen informasjon om andre personers helse X Det søkes om avdelingsleder(e)s godkjenning av deltagelsen i prosjektet X Det søkes om avdelingsleder(e)s godkjenning til bruk av deltagernes arbeidstid (hvis aktuelt)	
6 LAGRING AV DATA	
Skal elektroniske data som samles inn lagres ved sykehuset? ☐ Ja X Nei Hvis ja, hvordan skal dette lagres?	
7 DATO FOR UTFYLLING	
Sted og dato Innsbruck, Østerrike, 21.11.2014	Utfylt av: Hege Sjøvik

III: Interview guide

Intervju guide

- **(1)**Kan du først fortelle kort om deg selv, hva slags erfaring du har og hvor lenge du har jobbet her? // *Can you tell shortly about yourself, what kind of experience/background you have, and how long you have been working here?*

- **(2)** Kan du beskrive jobben din? // *Can you describe your job?*

- **(3)** Hva er dine primære arbeidsoppgaver? // *What are your primary work tasks?*

- **(4)** Kan du beskrive din lederrolle og hva den innebærer? // *Can you describe your leader role and what this encompasses?*

- **(5)** Hvordan kom du inn i denne stillingen? // *How was your way into this position?*

- **(6)** Hva er, i følge deg selv, nødvendig for å lykkes i jobben din? // *What is, according to you, necessary to succeed in your job?*

- **(7)** Hva mener du er de største utfordringene i din stilling? // *What do you perceive as the biggest challenges in your job?*

- **(8)** Hvordan kom du i kontakt med Ahus sitt interne lederutviklingsprogram, "Det Personlige Lederskap"? //*How did you get in contact with Ahus' internal leadership development program "The Personal Leadership?"*

- **(9)** Hvordan synes du det var å delta i lederutviklingsprogrammet? // *How did you experience participating in the program?*

- **(10)** Hva opplevde du som (mest) nyttig? // *What did you experience as (most) useful?*

- **(11)** Hva opplevde du som mindre nyttig; noen ting som kunne vært komprimert eller totalt fjernet i følge deg? // *What did you experience as less useful; anything that could have been compromised or completely be removed according to you?*

- **(12)** Hva slags tilpassinger kunne vært gjort i programmet for å bedre møte dine behov? // *What adaptions could have been done to the program to better meet your needs?*

- **(13)** På hvilke måter, hvis noen, føler du at lederutviklingsprogrammet har endret deg som leder? // *In what ways, if any, do you feel the leadership development program has changed you as a leader?*

- **(14)** Hvordan vil du beskrive støtten du får fra din nærmeste leder? // *How will you describe the support you get from your closest leader?*

- **(15)** Er det noen former for støtte du finner mer hjelpsom enn andre? // *Is there any kinds of support you find more helpful than others?*

- **(16)** Hvis du kunne konstruere ditt eget personlige støtteapparat/-program, hvordan hadde det sett ut/hva hadde det inneholdt? // *If you could construct your own personal support program, what would it encompass?*

- **(17)** Føler du at du får nok tilbakemeldinger på jobben du gjør? // *Do you feel you get sufficient feedback on your work?*

- **(18)** Hvordan opplever du deg selv som leder? // *How do you perceive yourself as a leader?*

- **(19)** Er det ellers noe du vil tilføye? // *Is there anything else you want to add?*